VETERANS MEMORIAL SENIOR CENTER

ADAPTIVE PHYSICAL EDUCATION

1455 Madison Avenue, Redwood City, CA 94061-1549 (650) 368-7732

Dear Dr._____

Your patient, _____, desires to enroll in an Adaptive Physical Education class offered at the Veterans Memorial Senior Center in Redwood City. This program, formerly sponsored by Cañada College, continues to operate here thanks to grants from the Sequoia Healthcare District, Kaiser Permanente, and Palo Alto Medical Foundation. Based on your input, the student will have an individually designed fitness program with their needs, interests, and abilities in mind. This program is not a substitute for physical therapy; rather, we offer an educational program for medically stable persons with a focus on lifelong fitness. Our program emphasizes cardiovascular conditioning, muscular strength, flexibility, balance and fall prevention, and social interaction.

For effective and safe programming, we are required to have a Physician's Approval form completed prior to his or her participation. After you have completed the attached form, you may return it to your patient or fax it directly to us at (650) 350-3249. Thank you for your input, and we appreciate your taking the time to complete this. We look forward to having your patient participate in our Program!

If you have any questions or comments about our program, please call us at (650) 368-7732 or visit us at our website: www.adaptivepevmsc.org

Sincerely,

Barbara McCarthy, M.A., Registered Kinesiotherapist
Scott Lohmann, M.A., Fitness and Aging Specialist

CONSENT FOR RELEASE OF INFORMATION:

PATIENT SIGNATURE_____ DATE_____

PHYSICIAN'S APPROVAL
FOR ADAPTIVE PHYSICAL EDUCATION

NAME_____ DATE OF BIRTH_____

MEDICAL DIAGNOSIS (ES) AND HEALTH STATUS: _____

_____

_____

DATE OF LAST EXAM_____ BLOOD PRESSURE_____ PULSE_____

MAXIMUM LIMITS FOR EXERCISE: HEART RATE_____ BLOOD PRESSURE _____

WHICH ACTIVITIES WOULD BE MOST BENEFICIAL FOR YOUR PATIENT?

_____

_____

WHAT WOULD YOU LIKE TO SEE THIS PERSON ACCOMPLISH?

_____

_____

_____

PLEASE LIST SPECIFIC FUNCTIONAL LIMITATIONS (i.e. walking, balance, vision, speech, self care):_____

_____

_____

ARE THERE ANY OTHER MEDICAL PROBLEMS OR SITUATIONS THAT WE SHOULD BE AWARE OF (regarding safety, communication, etc.)?

_____

_____

ADDITIONAL COMMENTS, INCLUDING YOUR PATIENT'S POTENTIAL/ MOTIVATION:

_____

_____

_____

PHYSICIAN'S SIGNATURE_____ DATE_____

ADDRESS_____

PHONE_____ FAX_____