

PHYSICIAN'S RECOMMENDATION and MEDICAL VERIFICATION  
FOR ADAPTIVE PHYSICAL EDUCATION

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

MEDICAL DIAGNOSIS(ES) AND STATUS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ PERMANENT/CHRONIC \_\_\_\_\_ TEMPORARY (estimated duration): \_\_\_\_\_

DATE OF LAST MEDICAL EXAM \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_

RESTING PULSE \_\_\_\_\_ SUGGESTED TARGET HEART RATE DURING EXERCISE \_\_\_\_\_

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CHECK HERE IF YOU WOULD LIKE A BRIEF PROGRESS REPORT EACH SEMESTER: \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NAME (PRINTED) \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_