PHYSICIAN’S STATEMENT AND MEDICAL RELEASE FORM

To the Physician of: ______________________________:

The Adapted Physical Education Program from IUPUI’s School of Physical Education will conduct an exercise program at the National Institute for Fitness and Sport (NIFS) for individuals with disabilities. The mission of the Ability Fitness Program (AFP) is to enhance physical performance, fitness and health in these individuals. AFP will strive to improve the quality of life, physical and psychological well being, and activities of daily living through physical movement and educational programming.

The above named individual has applied to participate in the Ability Fitness Program. This Program will meet for eight weeks and will be supervised by ACSM certified Health/Fitness Instructors at NIFS. Each participant will undergo a pre- and post-assessment unless deemed unable by the treating physician, tester and/or participant due to contraindications and/or physical ability. The assessment will consist of the following: resting heart rate, percent body fat, resting blood pressure, sub-maximal aerobic capacity, height and weight, flexibility, body circumference measurements, and muscular strength and endurance.

At the end of the program, a summary of the assessments along with participant’s success in the program will be sent to you. If you know of any medical or other reason why participation in this exercise program would be unwise for the applicant, please indicate so on this form. If you have any questions, please contact Dr. Katie Stanton, Ph.D. at (317) 274-2295.

REPORT OF PHYSICIAN
(Please check all that apply)

I, Dr. ____________________________, being the physician for ____________________________, and responsible for his/her care and/or treatment, know of no reason why this individual should not participate in the Ability Fitness Program.

Physician’s Signature ____________________________ Date: ____________
Address: __________________________________ Phone Number: ____________
__________________________________________________________________________

The following are exercise/activities the applicant may participate. Please check those that should be restricted:

___ Aerobic Dance ___ Jogging/Running ___ Walking
___ Arm Ergometer ___ Resistance Training ___ Other
___ Cross Country Ski ___ Stair Climbing
___ Machine ___ Stationary Cycling
___ Other recommendations (include contraindicated exercises due to medication, disability, etc.)

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