

To Participant or Parent(s)/Guardian(s) thereof:

Please fully complete the **Release of Medical Information form** on the next page. Do not complete the Medical Information Form – this is to be completed by the appropriate physician.

Please **forward the following items** to the appropriate physician:

1. Release of Medical Information Form
2. Medical Information Form

RELEASE OF MEDICAL INFORMATION

TO: \_\_\_\_\_  
(Physician)  
FROM: Manny Felix, Ph.D., Director, Special Populations Programs  
Adult Therapeutic Physical Fitness Program  
DATE: \_\_\_\_\_  
RE: Request for Medical Information on \_\_\_\_\_  
(Prospective Participant)

Attached you will find a **Medical Information Form** as it pertains to the individual identified above. The information on this form is utilized by the Adult Therapeutic Physical Fitness Program which has the following objectives:

- 1. To develop and maintain a functional exercise program upon recommendation of medical personnel;
- 2. to provide a program for the development of muscular and cardiovascular fitness; and,
- 3. to provide an environment for social interaction and, if needed, enhance the psychological needs and adjustments of the individual for an active role in his or her environmental setting.

Below you will find the signed **Authorization for Release of Information** giving permission for you to release appropriate medical information. Should you have any questions regarding this request, or the signed permission statement below, please do not hesitate to contact the Special Populations Programs office. Thank you in advance for your prompt response. Your cooperation is greatly appreciated.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Prospective Participant \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Name of Physician \_\_\_\_\_

I authorize \_\_\_\_\_  
(Name of Medical Facility)

to release medical history and/or diagnostic information to include any physical therapy or occupational therapy information to the UW-L Special Populations Programs, 114 Wittich Hall, UW-La Crosse. The purpose of this disclosure is to assist the staff of the Special Populations Programs in developing an individualized adult therapeutic physical fitness program for the above-named participant.

This request is a(n): \_\_\_initial request (or) \_\_\_medical update.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Please return Medical Information Form to:

Special Populations Programs  
114 Wittich Hall, UW – La Crosse, La Crosse, WI 54601  
Director's Phone: (608) 785-8691 Office Phone: (608) 785-8690  
Fax: (608) 785-8206 Email: specialpops@uwlax.edu

**MEDICAL INFORMATION FORM**

Participant Name \_\_\_\_\_  Male  Female  
 Address \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Last Exam \_\_\_\_\_  
 Impairment \_\_\_\_\_  
 Describe Limitation(s) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Severity of the Condition:  Chronic  Acute  Permanent  Temporary

Functional Capacity of Individual

- Unrestricted – no restrictions need to be placed on the individual relative to vigorousness or type of activity.
- Restricted – individual’s condition is such that the intensity and type of activity needs to be limited (check one category below).
  - Mild – ordinary physical activity need not be restricted, but unusually vigorous efforts need to be avoided.
  - Moderate – ordinary physical activity needs to be moderately restricted and sustained strenuous efforts need to be avoided.
  - Limited – ordinary physical activity needs to be markedly restricted.

Is individual taking medication?  yes  no

If yes, for what purpose \_\_\_\_\_

Anatomical Analysis

Indicate joint and/or muscle groups in which physical activity should be limited or avoided

<b>JOINT OR MUSCLE GROUP</b>	<b>Limited</b>	<b>Avoided</b>	<b>Right</b>	<b>Left</b>	<b>Both</b>

Remarks \_\_\_\_\_  
 \_\_\_\_\_

Remedial (check if applicable): Individual’s condition is such that defects or deviations can be improved or prevented from becoming worse through the use of carefully selected exercises. The following are types of exercises recommended for this individual’s condition. (Please be specific.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician’s Name (print) \_\_\_\_\_  
 Signed \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_