Monterey Peninsula College Adapted Physical Education
980 Fremont Street, Monterey, CA 93940
(831) 646-4070 FAX (831) 646-4171

Exercise Referral

Date:_____

Student's Name _____ **Student ID:** _____

Address _____ **City, State, Zip**_____

Phone _____ **Date of Birth** _____

DIAGNOSIS:_____

The above mentioned disability is?

[ ] Permanent/Chronic
[ ] Prone to exacerbation
[ ] Temporary (date of re-evaluation or estimated duration of disability: _____
[ ] Observable
[ ] Non Observable

Disability Verification and Classification: I verify this student meets the disability criteria for the following classifications:

Primary Disability		Secondary Disability	
[ ] Mobility: Wheelchair	[ ] D. D.	[ ] Mobility: Wheelchair	[ ] D. D.
[ ] Mobility: Crutches	[ ] ABI: Stroke	[ ] Mobility: Crutches	[ ] ABI: Stroke
[ ] Mobility: Cane	[ ] ABI: Traum. Brain Injury	[ ] Mobility: Cane	[ ] ABI: Traum. Brain Injury
[ ] Mobility: Limited	[ ] LD	[ ] Mobility: Limited	[ ] LD
[ ] Visual: Blind	[ ] Psychological	[ ] Visual: Blind	[ ] Psychological
[ ] Visual: Low Vision	[ ] Other: Diabetes	[ ] Visual: Low Vision	[ ] Other: Diabetes
[ ] Hearing: Deaf	[ ] Other: Seizures	[ ] Hearing: Deaf	[ ] Other: Seizures
[ ] Hearing: Hard of Hearing	[ ] Other: Environ. Illness	[ ] Hearing: Hard of Hearing	[ ] Other: Environ. Illness
[ ] Speech	[ ] Other: _____	[ ] Speech	[ ] Other: _____

Other Specific Limitations: This student exhibits the following limitations.

[ ] Limited ROM: _____
[ ] Loss of motor coordination: _____
[ ] Muscular imbalance: _____
[ ] Muscular weakness: _____
[ ] Paralysis: _____
[ ] Sensory loss:_____
[ ] Spasticity: _____
[ ] Hypertension
[ ] Hypotension
[ ] Impaired judgment
[ ] Language problems
[ ] Memory loss
[ ] Other:_____

COMMENTS:

_____

_____

(over)

MEDICATIONS:

_____

_____

Functional Limitation Verification: I certify that this student's disability affects his/her ability to do the following major life activities.

[ ] Perform basic care for one self
[ ] Develop basic skills
[ ] Develop cognitive skills
[ ] Develop communication skills
[ ] Traverse significant distances in a timely way
[ ] Climb stairs and negotiate other physical obstacles
[ ] Perform manual tasks
[ ] Deal with disability and related personal issues
[ ] Develop physical education and related health skills
[ ] See or process texts, handouts, other printed materials
[ ] Hear or process lecture, student discussion, and related oral presentations
[ ] Produce class notes, homework assignments, and other written course requirements
[ ] Interact with college instructors, counselors and other personnel related to special needs

EXERCISE RESTRICTIONS / RECOMMENDATIONS

[ ] Limited restriction [ ] Moderate restriction [ ] As Tolerated by Student

Please describe (Indications or Contra-indications): _____

_____

I recommend that this student may use the following available equipment/ activities.

	Yes	No		Yes	No
Arm cycles	[ ]	[ ]	Cable/ Pulley Exercises	[ ]	[ ]
Semi-Recumbent Bikes	[ ]	[ ]	Dumbbell Exercises (1-10 lbs.)	[ ]	[ ]
Parallel Walking Bars	[ ]	[ ]	Balance Activities	[ ]	[ ]
Outdoor Track	[ ]	[ ]	Floor Exercises/Table Exercises	[ ]	[ ]
Rowing Cycle	[ ]	[ ]	Range of Motion/ Stretching	[ ]	[ ]
Stationary Bicycles	[ ]	[ ]	Theraband Exercises	[ ]	[ ]
Stair Steppers	[ ]	[ ]	Theraball Exercises	[ ]	[ ]
Standing Frames	[ ]	[ ]	Weightlifting(15-180 lbs.)	[ ]	[ ]
Treadmills (w/ moderation)	[ ]	[ ]	Shoulder Wheels	[ ]	[ ]
Adapted Sports/Recreational Activities	[ ]	[ ]			

Physician's Name (Print) _____

Address: _____ **Date:** _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

Signature _____