Dear Doctor,
Your patient, (name)_______________________________wishes to start an exercise/instructional program through The Ohio State University Department of Recreational Sports. The activity will involve the following (type, frequency, duration, and intensity of) activities:

If your patient is taking medications that will affect his or her heart rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect on heart rate response):

Type of medication:
Effect:

Please provide any recommendations or restrictions that are appropriate for your patient in this exercise program.

Thank you.
Sincerely,
The Ohio State University Adapted Recreational Sports Program
RPAC B149
337 Annie & John Glenn Avenue
Columbus, Ohio 43210
614-292-0540 Fax

(Patient's name)__________________________________________has my approval to begin an exercise program with the recommendations or restrictions stated above.

_________________________  ______________________  __________________
Physician’s Signature     Date            Physician’s Phone Number