P.O. Box 266
Pine Forge, PA 19548
Phone: 610-326-4610 ext. 347
Phone: 800-830-0224 ext. 347
Fax: 610-326-3946
Email: prodgers@aecsda.com
Website: fit4youretreat.org

PHYSICIAN VERIFICATION FORM

Dear Physician:

Your patient, _____, would like to participate in our 2017 Fit 4 You Retreat in Pine Forge, Pennsylvania from July 9th – July 23rd, 2017. Our program will include supervised walking, aerobic exercising, strength building, swimming, readings of blood work comprising a lipid panel and glucose. Glucose Monitoring and Blood Pressure monitoring are included.

The physical assessments consist of the following: Please select what is permissible for your patient.

☐ Push Ups ☐ Crunches ☐ Sit and Reach ☐ Three Minute Step Test

Walking: ☐ ¼ Mile ☐ ½ Mile ☐ 1 Mile

Please list all prescriptions, over-the-counter medications, vitamins and herbal supplements that your patient is currently taking.

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any recommendations or restrictions that you might have regarding your patient's participation in this program, please, specify in the space below.

_____

_____

Thank you for taking time out of your busy schedule to complete this form.

Sincerely,

Joanne West, Director
Audrey Booker, BSN, SNP, MPH - Assistant Director
Joyce Parker, RN, DSN - Medical Coordinator

Physician's Recommendation

☐ I Approve this patient to participate in **FIT 4 YOU** Retreat with the recommendations stated above.
☐ I Disapprove this patient to participate in **FIT 4 YOU** Retreat.

_____ _____/_____/_____
Physician's Signature Date

PHYSICAL ASSESSMENT FORM

Date of Examination _____

Last Name _____ First Name _____ Middle Initial ____

Address _____

City _____ State _____ Zip _____

Birth Date (Month/Day/Year) _____/_____/_____ Telephone _____ Cell Phone _____

B/P _____ RESP: _____ Heart AP (Rest) _____ Weight _____ Height _____

Family History: Significant Illnesses, Accidents, Operations, Congenital Defects, Communicable Diseases and other Medical

Conditions: _____

_____

_____

Allergies: _____

_____

Physical	**Normal**	**Abnormal**	**Follow-Up Comments**
Skin	☐	☐	_____
Eyes	☐	☐	_____
Ears	☐	☐	_____
Nose	☐	☐	_____
Throat	☐	☐	_____
Mouth	☐	☐	_____
Cardiovascular	☐	☐	_____
Respiratory	☐	☐	_____
Glands	☐	☐	_____
Gastrointestinal	☐	☐	_____
Genitourinary	☐	☐	_____
Neurological	☐	☐	_____
Muscular Skeletal	☐	☐	_____
Nutritional Status	☐	☐	_____
Mental Health	☐	☐	_____

Physician's Name _____

Office Telephone _____ Fax Number _____

Current Address _____

City _____ State _____ Zip Code _____

Physician's Signature _____ Date _____