



Ms. Gina Mabrey
Jacksonville State University
700 Pelham Road North
204 A Pete Mathews Coliseum
Jacksonville, Alabama 36265-1602

Dear Personal Physician:

Employees and students at Jacksonville State University are eligible for participation in a comprehensive, campus based wellness program. The purpose of the program is to promote good health, physical fitness, and a knowledgeable understanding of the benefits of proper lifestyle management. One aspect of the program involves voluntary participation in a health-fitness evaluation. The purpose of the evaluation is to help individuals recognize components of their lifestyle that may be detrimental to their health and well-being. The evaluation includes a self-administered medical and lifestyle history profile, body fat test, pulmonary function tests, muscular/joint strength and flexibility tests, a stress vulnerability assessment, rest and exercise electrocardiograms, and maximum oxygen uptake. Once all of the data is collected and analyzed, the individual is counseled regarding an appropriate physical fitness program as well as other lifestyle modifications which may be indicated.

The purpose of this letter is to make this program as comprehensive and as safe as possible. In order to do so, we feel it is necessary to inform you that your patient: _____ has asked to participate in the previously described health-fitness evaluation program; but before doing so, we would like to elicit your concerns regarding your patient (Please see the Personal Physician Questionnaire on the second page of this letter).

If you have any questions, please don't hesitate to contact me at (256) 782-5114.

Thank you for your time.

Sincerely,

Ms. Gina Mabrey, Coordinator of the JSU Wellness Center

Personal Physician Questionnaire

I have no medical related reservations or otherwise which would prevent my patient,

from participating in the JSU Wellness Testing Center's health-fitness evaluation program and/or exercise program. I understand that by signing this form I am not assuming any responsibility for the administration of the health-fitness evaluation and/or exercise program.

Physician's Signature _____

(Please type or print)

Name of Physician: _____

Address: _____

Phone #: _____

Please check here if you would like a copy of the data obtained sent to your office.
Please fill in the information below if it is available.

Cholesterol: _____ HDL: _____

Triglycerides: _____ LDL: _____

Blood Pressure: _____ Date of last assessment: _____

(Please enclose a copy of the last ECG, if available.)

Physician's Comments:

Personal Physician Questionnaire Patient Release

I hereby authorize the release of all patient information relative to my medical history for my health-fitness evaluation at Jacksonville State University's Wellness Testing Center.

Signed: _____ Date: _____

Please return to:

Ms. Gina Mabrey
Jacksonville State University
Wellness Center
700 Pelham Road North Jacksonville, AL 36265

If you have any questions, please call the Wellness Testing Center at 782-5114.