**TO BE COMPLETED BY STEP PHYSICAL THERAPY**

**Dear Doctor,**

Your patient would like to participate in the **STEP Physical Therapy Modified MS Triathlon.** This triathlon is tailored to those diagnosed with MS – 30 minutes of swimming (pool), cycling (recumbent bike), and running/walking (harnessed treadmill).

Your patient will need **medical clearance** from you to participate in the triathlon since it involves physical exertion. Please complete the form below and return it by fax or mail to STEP Physical Therapy by \_\_\_\_\_\_\_\_\_\_\_\_ (date). Patient authorization for release of information is below. Please contact Megan Frost at 651-766-0080 if you have any questions about the triathlon.

Sincerely,

STEP Physical Therapy

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**TO BE COMPLETED BY PARTICIPANT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(Print Participant‘s Name) (Date of Birth) (Phone Number)

authorize my doctor to release the following requested information to STEP Physical Therapy for the purpose of participating in the **Modified Triathlon**.

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

Signature of Participant Date

**TO BE COMPLETED BY PHYSICIAN**

My patient does have multiple sclerosis and may participate in the **STEP Physical Therapy Modified Triathlon** at the level of activity he/she can tolerate.

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

Physician‘s Name (Please print) Phone Number

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

Physician‘s Signature Date

**Please complete and FAX to STEP Physical Therapy at 651-766-7560**