FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

HEALTHY WEIGHT AND YOUR CHILD

PROGRAM REFERRAL

Date ____________________

PATIENT INFORMATION

Patient Name:	Date of Birth:
Parent/Guardian Name:	Phone:
Address:	
E-Mail:	

PARTICIPANT ELIGIBILITY

Child must meet all qualifications to participate in the program.

- ☐ **Child is 7-13 years old**
- ☐ **Child's has a body mass index (BMI) of the 95th percentile or higher**
- ☐ **Child is cleared to participate in 60 minutes of moderate to vigorous physical activity**
- ☐ **Adult agrees to participate in the program**

NOTES

PROVIDER INFORMATION

Provider Name:	Phone:
Signature:	Fax:

PATIENT AUTHORIZATION

Parent/Guardian Signature:	Date:

By signing this form, I authorize my physician to disclose my screening results to the YMCA for the purpose of determining my eligibility for the YMCA's Healthy Living Program and conduction other activities as permitted by law. I understand that I am not obligated to participate in this screening program and that this authorization is voluntary. I understand that I may revoke this authorization at any time by notifying my physician in writing. Any revocation will not have an effect on actions taken before my physician received my written revocation.

Please fax completed form to Center for Health Innovation at 844-671-9053.