Referral Form

Child's Name_____ Date of Birth_____

Parent's Name_____Phone:_____

Address_____

City_____State_____Zip_____

Email:_____

PHYSICAL EVALUATION

Weight_____ Weight Percentile_____ Height_____ Height Percentile_____

Body Mass Index (BMI)_____ BMI Percentile_____

Cholesterol (If available)_____Blood Pressure_____

Allergies: List:_____

Does this child have any of the following medical conditions?

☐ Hypertension
☐ High cholesterol or triglycerides
☐ ADHD
☐ Asthma
☐ High blood sugar, insulin resistance or diabetes
☐ Orthopedic problems
☐ Other_____

Does this child take any medications or supplements? ☐ Yes ☐ No If yes, please list all medications:

_____

Additional
Comments_____

The Fit4AllKids: Weight Management and Fitness for Families consists of:

- Fitness screening-evaluation of cardiovascular response to exercise by heart rate, flexibility and strength
- Use of resistive equipment for strengthening, cardiovascular workout and fat reduction, with instruction for proper use of equipment without constant monitoring or supervision.
- Low impact aerobics classes.

Based on my evaluation, there is no contraindication to participation in the above-described program.

_____ _ _____
Physician's signature: Date

Physician's Name_____Phone:_____

Address:_____

Fax to: All Children's Hospital 727-767-8601 Questions, please call: 727-767-6923