



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY



# KAMP K'AANA PATIENT REFERRAL

Date \_\_\_\_\_

## PATIENT INFORMATION

Patient Name:	Date of Birth:
Parent/Guardian Name:	Phone:
Address:	
E-Mail:	
Primary Language of Household: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	

<b>PARTICIPANT ELIGIBILITY</b>
<b>Child must meet all qualifications to participate in the camp.</b>
<b>Child is 10-14 years old by June 10th, 2018 (start of Kamp K'aana)</b>
<input type="checkbox"/> <b>Child has a body mass index (BMI) of the 95<sup>th</sup> percentile or higher</b>
<input type="checkbox"/> <b>Child is cleared to participate in moderate to vigorous physical activity</b>
<input type="checkbox"/> <b>Provider will fax list of medications and immunizations records of child to the Y along with referral form.</b>
<b>NOTES</b>

## PROVIDER INFORMATION

Provider Name & Clinic:	Phone:
Signature:	Fax:

## PATIENT AUTHORIZATION

Parent/Guardian Signature:	Date:
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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 YMCA of Greater Houston at 1-888-978-7606.**