



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

## YMCA's Healthy Weight & Your Child (HWYC) Referral Form

### Patient Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female  
Last First MI mm/dd/yyyy

Parent(s)/Guardian(s) Name: \_\_\_\_\_

English speaking?  yes  no If no, language: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Child Anthropometrics

Height: \_\_\_\_\_ ft \_\_\_\_\_ in Weight: \_\_\_\_\_ lbs Capture date \_\_\_\_\_

BMI: \_\_\_\_\_ BMI Percentile (must be > 95%): \_\_\_\_\_ Age: \_\_\_\_\_

- I talked to the patient and their parent/guardian about this referral. They are aware it is a 15 week lifestyle change program.
- I approve this patient to participate in HWYC program where he/she will engage in physical activity

### Special Notes (optional)

### Referrer Information

Provider's Name: \_\_\_\_\_

Medical Office: \_\_\_\_\_

**The above named participant is cleared to participate in this active program**

\_\_\_\_\_  
Healthcare Provider Signature

\_\_\_\_\_  
Date

Please submit a completed referral form by secure fax to **231.525.2890** or email (below)  
Questions? Contact our Program Coordinator, Kelli: **855.278.6836** | [kdelong@muskegonymca.org](mailto:kdelong@muskegonymca.org)