FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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

Patient Information

Name: _____ DOB: _____ ☐Male ☐Female
mm/dd/yyyy

Parent(s)/Guardian(s) Name: _____

Address: _____ City: _____ Zip:_____

Phone: _____ Email: _____

Child Anthropometrics

Height: _____ ft _____ in Weight: _____ lbs Capture date _____

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 **855.278.6836** | **ydpp@muskegonymca.org**