Bee Fit 4 Kids Pediatric Weight Management Program Referral Form
(to be completed by the Referring Physician)

Child's Name: _____ Date of Birth: _____
Parent's Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip Code: _____

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
_____

Do you feel that this child should **not** participate in a physical fitness regimen? □ Yes □ No
If yes, please explain:
_____

Additional Comments: _____
_____
_____

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

_____ _____
Physician signature Date

Physician's Name _____ Phone: _____
Address: _____