SUPERFIT KIDZ FITNESS/MEDICAL QUESTIONAIRE FORM

PROGRAM:

Please complete and return a participation form for each child reenrolled in this program. The information on these forms will be used to evaluate the effectiveness of the program. Thank You.

Date: _____

Kids Name: _____ Date of Birth: _____ Gender: _____

Parent's/Guardian Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Fax: _____

School/Grade: _____

Insurance Provider: _____

PHYSICAL EVALUATON:

Weight: _____ Weight Percentile: _____ Height: _____ Height Percentile: _____

Body Mass Index (BMI): _____ BMI Percentile: _____ Blood Pressure: _____ Cholesterol (if available): _____

Allergies: _____Yes _____No If yes, please list all allergies: _____

Does this child have any of the following medical conditions?

_____ Hypertension _____ Asthma _____ High cholesterol or triglycerides

_____ADHD _____ Orthopedic problems _____ Sleep apnea

_____ High blood sugar, insulin resistance or diabetes _____ Date of last tetanus shot

_____ Other

Does this child take any medications or supplements? _____ Yes _____No If yes, please list all medications:

_____

Additional Comments:

_____

Physician's Name: _____ Phone: _____ Fax: _____

Address: _____

Physician Signature: _____ Date: _____