FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Kamp K'aana/Healthy Kids For Life
REFERRAL FORM
YMCA of Greater Houston

Patient Name: ____
Date of Birth: ____________ Phone: ______________ E-mail:_________________
English speaking? _____ Spanish speaking? _______ Other: _________________

To qualify participants must:

- Be between 10-14 years of age
- Be $\geq$95th percentile of Body Mass Index (BMI) for their gender and age, have cognitive ability to participate, be able to walk without assistance.

********To be completed by health care provider*******

Body Mass Index
Height: ______ in Weight (must be **at or below** 250 lbs.): ______ lbs.
BMI: _____ kg/m
Body Mass Index Percentile (must be **at or above** 95%): ________
Male: ______   Female: ______

Special health considerations such as sleep apnea, diabetes, or heart condition (please specify):
____
____
____

Participation Information (check one)
I _____ DO _____ DO **NOT** recommend that this patient participate in Kamp K'aana, a residential weight management program where he/she will engage in daily physical activity with a meal plan designed by TCH dietitians.

I _____ DID obtain patient authorization to release this information to the YMCA (please complete form below).

AUTHORIZATION TO RELEASE HEALTH INFORMATION.
Provider Name: ________________________ Practice Name: ________________
Provider Signature: ____________________________ Date: ________________
Practice Contact: ___________________ Phone: ____________ Fax: __________

AUTHORIZATION TO RELEASE HEALTH INFORMATION

****To Be Completed by Patient****

I agree and request that the health information on the front of this form be released to the YMCA of Greater Houston for the purpose of referring my child to Kamp K'aana (Kids Achieving Activity and Nutrition Awareness). I have the right to revoke this authorization at any time by writing to the health care provider named on the Kamp K'aana Referral form, except to the extent that the action has already been taken based on this authorization.

I understand that signing this authorization is voluntary. I further understand that my child's treatment, payment, enrollment in a health plan, and or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I understand that information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law.

Patient name (print): ____

Signature of Parent or Legal Guardian: _____________________________________

Thank you for your referral!
Please fax the completed form to
1-888-978-7606
http://www.ymcacampcullen.org/kamp-kaana/