



**YMCA OF SNOHOMISH COUNTY  
ACT! (Actively Changing Together)  
Referral Form**

<b>Program Eligibility</b> <ul style="list-style-type: none"> <li>• BMI &gt;85% percentile for age</li> <li>• Adult and child both have a strong personal desire for change</li> <li>• Able to cooperate in a group setting</li> </ul>	<b>Age Group</b> <input type="checkbox"/> Kids 8-11 <input type="checkbox"/> Teens 12-14	<b>Start Date</b> <input type="checkbox"/> Fall (Sept) <input type="checkbox"/> Winter (Jan)
	<b>YMCA Branch:</b> <input type="checkbox"/> Everett <input type="checkbox"/> Marysville <input type="checkbox"/> Mill Creek <input type="checkbox"/> Monroe <input type="checkbox"/> Mukilteo	

**Parent/guardian completes this section:**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F

Parent/guardian Name \_\_\_\_\_

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

Home Ph (    ) \_\_\_\_\_ Cell Ph (    ) \_\_\_\_\_

Email Address \_\_\_\_\_

How did you find out about ACT! ? \_\_\_\_\_

I agree to allow YMCA staff to contact me for enrollment and participation in this program.

\_\_\_\_\_  
**Parent/Guardian Signature** Date

Please note information that YMCA ACT! program staff should know before starting your child in an exercise program:

Asthma     Type 2 Diabetes     ADHD     Hypertension     Food Allergy

Other: \_\_\_\_\_

**Doctor/ARNP/RN completes this section:**

Patient Weight \_\_\_\_\_ (lbs)   Height \_\_\_\_\_ (in)   BMI %ile o 85-95%   o >95%ile   Date Measured \_\_\_\_\_

Doctor/RN/ARNP Name \_\_\_\_\_ Clinic/School Stamp \_\_\_\_\_  
Print or Stamp

Ph (    ) \_\_\_\_\_ Fax (    ) \_\_\_\_\_

The above mentioned patient is cleared to participate in the ACT! nutrition and exercise program.

\_\_\_\_\_  
**Doctor/ARNP/RN Signature** Date

**Please fax completed Referral Form to:**  
  
Lynnette Monpas  
ACT! Program Manager  
(P) 360-453-2190  
(F) 1-844-860-1196 (HIPAA Secure Fax)