



KIDS N FITNESS[®] and KIDS N FITNESS[®] JUNIOR: Research Study on Pediatric Weight Management
Phone: 323-361-3174 Fax: 323-361-8387

SECTION I: MUST BE FILLED OUT BY PARENT OR LEGAL GUARDIAN

Child's name: _____ Date of birth: _____

Parent or guardian's name: _____ Relationship to child: _____

Home address: _____

Contact number: _____ Email address: _____

Primary language spoken at home (check one): ☐English ☐Spanish ☐Other: _____

Your signature indicates that you would like to be contacted by the Kids N Fitness[®] staff to learn more about this research study.

Parent signature _____ Date _____

Please have your physician or nurse practitioner complete section II and fax to 323-361-8387

Note: Because this is a research study evaluating the effects of our educational and exercise program on weight velocity, children with medical conditions or on medications known to affect weight will not be eligible to participate. This study is open to children ages 3-16.



KIDS N FITNESS[®] and KIDS N FITNESS[®] JUNIOR: Research Study on Pediatric Weight Management
Phone: 323-361-3174 Fax: 323-361-8387

SECTION II: MUST BE COMPLETED BY A PHYSICIAN OR NURSE PRACTITIONER

Referred by: _____ Date referred: _____

Hospital/clinic/school: _____ Telephone #: _____

Address: _____

Weight management needs:

- ☐ Increasing weight velocity
- ☐ Overweight for age/gender (>85th percentile)
- ☐ Severely overweight for age/gender (>95th percentile)

Date of most recent visit: _____ Height: _____ Weight: _____ BP: _____ / _____

☐ This child has no underlying health problems that will preclude or that may interfere with him/her participating in 45 minutes of physical activity during class as well as regular activity throughout the week.

☐ This child does not have diabetes.

☐ This child does not have hypertension secondary to another disease.

☐ This child does not have any cardiac or renal disease, or any other medical condition that may affect blood pressure.

Comments _____

☐ This child is not on any medications known to affect blood pressure, blood glucose or weight loss.

Please list any medications this child is currently taking: _____

Please respond to the statement below, if the child that you are referring is 8 years old or over:

☐ This child has the reading and writing skills to be able to participate at a 3rd-grade level.

Comments _____

**Optional (preferred): Please forward growth chart or most recent 1-year height/weight history.*

Physician signature: _____ Date: _____