

Fitness and Nutrition Program

Dear Parent or Guardian,

FANTastic Kids is a community based physical activity and nutrition program being offered by Boston Medical Center's Nutrition and Fitness for Life Program, two community health centers and the Greater Boston YMCA's. FANTastic Kids is for boys and girls ages 8-12 that are overweight, and are referred by their primary care doctor. Program sessions are twice a week for 12 weeks.

There are two parts to this application that must be completed in order to register for the program:

- 1) The Participant Application and Consent Form (below) to be completed by you and,
- 2) The Medical Eligibility Form (page 4) which is to be completed by your child's primary care provider.

Once you have both forms completed, please contact the Site Coordinator at the site you would like your child to attend. Registration will be confirmed by phone if your child is eligible for the program.

The FANTastic Kids Program is offered at the following YMCA and community health center sites:

- **Mattapan Community Health Center, 1425 Blue Hill Ave., Mattapan, MA 02126. Please contact: Tina Evans (617) 898-9128 or evanst@matchc.org**
- **Dot Well Program at Dorchester House, 1353 Dorchester Ave. Dorchester, MA, 02122 Please contact: Helio Brandao (617) 740-2388 or helio.brandao@dorchesterhouse.org**
- **Dorchester Family YMCA, 776 Washington Street, Dorchester, MA, 02124. Please contact: Rebecca Cooper, 617-436-7750 or rcooper@ymcaboston.org**
- **Roxbury Family YMCA, 285 Martin Luther King Blvd., Roxbury, MA, 02119. Please contact: Chris Rule, 617- 427-5300 ext. 277 or crule@ymcaboston.org**
- **Oak Square YMCA, 615 Washington Street, Brighton, MA, 02135. Please contact: Kaitlin Jolly (617) 888-1778 or kajolly1@gmail.com**

Please keep this page for your records.

PARTICIPANT APPLICATION FORM

Child's Name: _____ Child's Gender (circle): Male/Female
Last First Middle initial

Child's Address: _____
Street Apt. # City/Town Zip code

Child's Telephone: _____ Child's Age at start of program: _____ Birth date ___/___/___
Month/day/year

Child's School: _____ Grade: _____

Parent/Guardian Information

Your Name: _____ Your Relationship to the child listed above: _____

Phone numbers: Home: _____ Work: _____ Cell: _____

Name of other Parent/Guardian: _____ Relationship to child: _____

Phone numbers: Home: _____ work: _____ Cell: _____

Emergency Contact Information

Name: _____ Relationship to child: _____

Phone numbers: Home: _____ Work: _____ Cell: _____

Can your child be released to this person? Yes No

Medical Information

Does your child have allergies, medical conditions or behavioral issues? (Allergies to medication, food, latex, bee stings, etc., or asthma, diabetes, or other conditions requiring medications: please list:

Primary Care Provider Information

Primary Care Health Center/Hospital: _____ Child's Primary Care Provider:

Phone Number: _____ Address: _____

Transportation Agreement

I hereby agree that my child will get to and from the Program in the following way(s):

____ I or my designee, _____, will drop off and pick up my child at the Program.
(Please list all possible designees) _____

____ My child will take public transportation by himself/herself

____ Other (please specify) _____

(Signature of parent/guardian for child under 18)

(Date)

INFORMED CONSENT FORM

My child has been referred by her/his primary Care provider to take part in the FANtastic Kids Program (“the Program”) organized by the Nutrition and Fitness for Life Program at the Boston Medical Center (BMC) and one of the participating YMCA locations or two community health centers. The program will involve two hours of nutrition and two hours of fitness activities weekly.

Before my child can be accepted into the Program, I understand that I must discuss my child’s participation with her/his regular health care provider and have the provider complete the attached form.

I understand that my child will be undergoing physical exertion while participating in the Program. I realize that there is always a risk of injury while exercising, even though participants in the program will be closely monitored.

I understand that in the event physical injury occurs while my child is participating in the Program, medical treatment and assistance will be available in the same manner and to the same extent available for injuries that my child may suffer due to other circumstances. However, I understand that no formal mechanism to compensate me for the cost of the treatment or the cost of other losses that my child may suffer can be or is guaranteed.

I agree to waive and release all claims and causes of action that I may have or acquire against Boston Medical Center and/or any of their trustees, officers, employees, agents or volunteers for injury, loss, or damage which I or my child may suffer which are in any way connected with participation in the Program.

I authorize release of relevant details from my child’s medical record and for my child’s completed registration and medical eligibility forms to be kept on file by the Nutrition and Fitness for Life Program, at Boston Medical Center.

I understand that my child’s height and weight will be taken at the beginning and conclusion of the Fantastic Kids program. I understand that my child will also be asked to complete a short questionnaire at the beginning and conclusion of the program to assess her/his knowledge, attitudes and/or behaviors with respect to nutrition and physical activity. This information will be kept on file at Boston Medical Center and its confidentiality carefully protected.

I hereby give permission for BMC, the participating community health centers and YMCA’s to reproduce any quotation, photograph or video of my son/daughter while participating in any FANtastic Kids sanctioned activity. Photographs may appear in program reports, grants and newsletters, on the BMC website, in marketing materials and in local/national publications.

I have had an opportunity to ask questions about the Program and my concerns have been addressed.

I hereby allow my child, _____, to participate in the Program. I understand that my consent will remain effective until either my child completes the Program, or I withdraw my child from the Program.

(Signature of parent or guardian for child under 18)

(Date)

For Site Coordinator (Please check):

- The participant DOES meet eligibility requirements.
- The participant DOES NOT meet eligibility requirement and will be referred to an appropriate program.

MEDICAL ELIGIBILITY FORM
TO BE COMPLETED BY YOUR CHILD'S PHYSICIAN

Patient's Name: _____ Date of Birth: _____

Height: _____ Weight: _____ BMI: _____ Date taken: _____

I have evaluated the patient for overweight: Yes ____ No ____ If yes, please complete the screening test form below.

My patient meets ALL of the following criteria for participation:

- ✓ Boy or girl age 8-12
- ✓ BMI ≥ 85%tile or increase ≥ 2 units/y
- ✓ Not a complex high-risk patient

If your patient does not satisfy all of the above criteria, he or she should NOT be referred.

I believe it is safe for my patient to participate in the Fantastic Kids Program. I am aware that there will be no physician on duty during the Program.

Physician Name: (please print) _____

Health Center or Hospital Address: _____

Other: _____

Phone Number: _____

 (Signature of Physician)

 (Date)

You will receive a "Patient Data Form" from Boston Medical Center summarizing your patients' experience with FANTastic Kids at the conclusion of the 12- week session.

Routine Screening Tests to Identify Pediatric Overweight

Please fill data in where available and circle fasting or non-fasting tests:

Date (m/d/y)	Type of test	Test	Patient value	Normal range &/or unit
	Anthropometric	Weight		Lbs or kg
	Anthropometric	Height		Inches or cm
	Vitals	Systolic/diastolic BP	/	mmHg
	Vitals	Pulse		Beats/min
	Fasting/Not fasting blood	Glucose		60-100 mg/dL
	Fasting/Not fasting blood	Insulin		<15 uIU/mL
	Fasting/Not fasting blood	HgbA1c		<6%
	Fasting/Not fasting blood	Total-c		<170 mg/dL
	Fasting/Not fasting blood	HDL-c		> 35 mg/dL
	Fasting/Not fasting blood	LDL_c		<100 mg/dL
	Fasting/Not fasting blood	BUN		6-22 mg/dL
	Fasting/Not fasting blood	Creatinine		0.3-0.7 mg/dL
	Fasting/Not fasting blood	ALT		5-40 U/L
	Fasting/Not fasting blood	AST		6-22 mg/dL
	Fasting/Not fasting blood	TSH		0.35-5.5 uIU/mL

Triglycerides, LDL, and insulin are always measured fasting.