

Health History Questionnaire

Child's Name _____ Date of Birth _____
Parent/caregiver's Name _____ Phone # _____
Address (street, city, and zip code) _____

- Has your child ever had any of the following conditions? If yes, please explain.

Heart Condition	No	Yes _____
High Blood Pressure	No	Yes _____
Diabetes or High Blood Sugar	No	Yes _____
Asthma or other Lung Condition	No	Yes _____
Seizure or Neurological Condition	No	Yes _____
Musculoskeletal Condition	No	Yes _____
Cancer or other serious illness	No	Yes _____

- Are there any additional medical conditions not noted above that may affect your child's safe participation in an exercise program? Yes No If yes, please explain below.
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- Is your child taking any medications? Yes No (we will review these later)
- Does your child have any serious allergies? Yes No _____

My signature below indicates that all information given is accurate.

I hereby give my Healthcare Provider permission to release any pertinent medical information to the GoKids Boston staff.

Member/parent signature _____ Date _____

Physician Clearance Statement

I agree with my patient's participation in GoKids Boston's exercise programs without restriction.
 I agree with my patient's participation in GoKids Boston's exercise programs with the following restrictions: _____

I do not agree with my patient's participation in an exercise program at this time. (If checked, the individual will not be allowed to join GoKids Boston)

Any additional medical information you feel we should be aware of:

Please provide this patient's most recent Clinic note, Exercise Stress Test, and Treatment Plan

Clinician's signature _____ Date _____
Print name _____, phone # _____
Affiliation _____, email _____

Thank you for this referral. We look forward to sending you periodic updates regarding your patients progress.

