



Physician Referral Form

Patient name: _____ DOB: _____

Parent/guardian name: _____

Address: _____ City: _____ Zip: _____

Telephone number: _____ Email: _____

Please check the YMCA location your family wants to attend.

Rite-Hite Family YMCA

Telephone: (414) 357-2827

Fax: (414) 354-0309

Southwest YMCA

Telephone : (414) 546-9622

Fax: (414) 546-9630

Northside YMCA

Telephone: (414) 265-9622

Fax: (414) 374-9459

West Suburban YMCA

Telephone: (414) 302-9622

Fax: (414) 778-4955

Patient Consent

I agree to allow the YMCA to contact me to participate in NEW Kids at the Y.

Parent/guardian signature

Date

Physician Information

Physician: _____ Specialty: _____

Address: _____ City: _____ Zip: _____

Telephone: _____ Fax: _____

Please note any information that a YMCA fitness coach should know before starting your patient in an exercise program:

The above named patient is cleared to participate in an exercise program.

Signature

Date