Health Care Provider's Examination

To be completed by a licensed practitioner.

Child's Name **Date of Exam:** **DOB:**

Age	**Height** (% ile)	**Weight** (% ile) BMI	BP
		Circle: Underweight Normal Overweight Obese	

Current Health Issues

Y **N**

☐ ☐ Allergies: Medication _____ Food _____ Other _____

Hx of Anaphylaxis to _____ Epi-Pen® ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (Please attach)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure Disorder: _____

☐ ☐ Other: (Please specify) _____

Current Medication (If relevant to the child's health and safety.)

Physical Examination (Check as applicable.)

	Normal	Abnormal	Comments
Eyes			
Ears, Nose & Throat			
Hearing			
Mouth & Teeth			
Neck (soft tissue)			
Cardiovascular			
Chest & Lungs			
Heart			
Abdomen			
Genitalia – Hernia			
Skin & Lymphatics			
Spine – Scoliosis			
Extremities			
Neurologic			

Participation Recommendations

The Wheels in Motion bicycling and nutrition program has been described to me and after examining this child, I certify that the above named child:

☐ may participate fully

☐ may participate with restrictions (please specify) _____

_____

☐ may not participate (Please do not sign below. Instead please contact Debbie Ennis at 978-257-8062)

DO NOT SEND PATIENT'S IMMUNIZATION RECORDS. We do not need, nor want, that information.

Note to licensed practitioner: The Wheels in Motion program will be tracking wellness outcomes via surveys approx. three months after the completion of the 6-week program. It would be helpful if you would perform weight, BMI and BP follow ups at that time. If you feel this child would benefit from additional pre and post health screenings, i.e. blood sugar, cholesterol, please indicate this and we will make accommodations for these indicators.

By signing below, you, as this child's personal care physician (or designee) are certifying that the above named child can participate in the Wheels in Motion program. Any and all restrictions have been noted above.

Licensed Practitioner's Name (print): _____

Licensed Practitioner's Signature: _____

Date: