Healthy Kids U Enrollment Form

Streator Family YMCA/OSF HealthCare

Participant Information: Please print clearly with complete information

Child's Name:_____ Date of Birth___/___/___ Age:_____ ☐ Male ☐ Female

Home Address:_____ City:_____ State:_____ Zip:_____

Home Telephone:_____ Grade (Fall 2018):_____ School:_____

Family Information:

Parent/Guardian 1 Name:_____ ☐ Male ☐ Female Preferred Method of Contact:_____

Email Address:_____ Cell Phone:_____ Work Phone:_____

Parent/Guardian 2 Name:_____ ☐ Male ☐ Female Preferred Method of Contact:_____

Sibling's Name:_____ Date of Birth___/___/___ Age:_____ ☐ Male ☐ Female

Sibling's Name:_____ Date of Birth___/___/___ Age:_____ ☐ Male ☐ Female

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Sibling's Name:_____ Date of Birth___/___/___ Age:_____ ☐ Male ☐ Female

Sibling's Name:_____ Date of Birth___/___/___ Age:_____ ☐ Male ☐ Female

Medical Information: Please print clearly with complete information

Please let us know of any important medical information that will allow us to better serve your child:

_____

_____

_____

Please let us know of any other information that would allow us to better serve your child and enhance his/her experience:

_____

_____

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5210 Healthy Habits Questionnaire

****The following two forms must be completed by each eligible child****

Child's Name:_____

1. How many servings of fruits or vegetables do you have a day? _____
   One serving is most easily identified by the size of the palm of your hand.

2. How many times a week do you eat dinner at the table together with your family? _____

3. How many times a week do you eat breakfast? _____

4. How many times a week do you eat takeout or fast food? _____

5. How much recreational (outside of school work) screen time do you have daily? _____

6. Is there a television set or Internet-connected device in your bedroom? _____

7. How many hours do you sleep each night? _____

8. How much time a day do you spend being active? _____
   (faster breathing/heart rate or sweating)

9. How many 8-ounce servings of the following do you drink a day?

   100% Juice _____ Whole Milk _____

   Water _____ Soda or Punch _____

   Fruit or Sport Drinks _____ Nonfat (skim), Low-Fat (1%), or Reduced-Fat (2%) Milk _____

10. Based on you answers, is there ONE thing you would be interested in changing now?
    Please check one box.

    - ☐ Eat more fruits or vegetables.
    - ☐ Eat less fast food/takeout.
    - ☐ Drink less soda, juice, or punch.
    - ☐ Drink more water.
    - ☐ Spend less time watching TV/movies and playing video/computer game
    - ☐ Take the TV out of the bedroom.
    - ☐ Be more active – get more exercise.
    - ☐ Get more sleep

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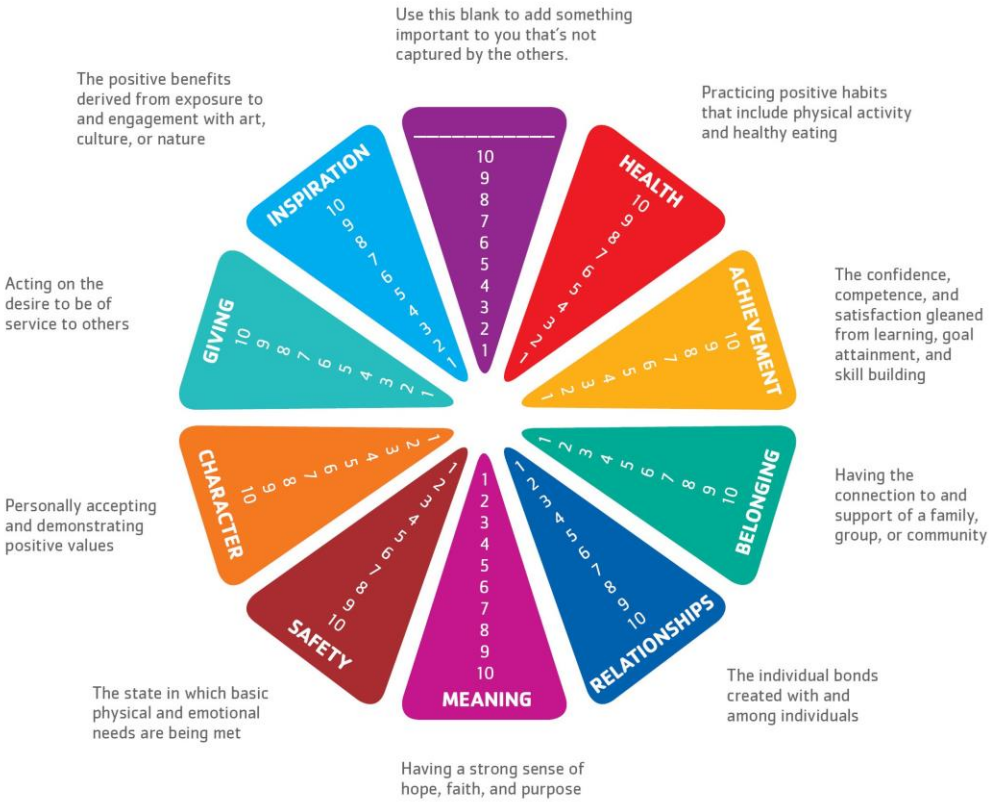
Wellness Wheel Questionnaire



Please rate the following dimensions from 1 to 10 based on your current assessment of your overall wellness.

Use the above descriptions as an aid in filling out the items below.

1. Inspiration:_____
2. Giving:_____
3. Character:_____
4. Safety:_____
5. Meaning:_____
6. Relationships:_____
7. Belonging:_____
8. Achievement:_____
9. Health:_____
10. Use this space to add something important to you that's not captured by the others and rate:

    _____ _____