Community Services
Time in, Outdoors Screening Form

Date of Initial Contact: _____ Name of screener: _____

Screening completed with: _____
Name Agency Phone

Name of Client: _____ Gender: ___ M ___ F

Age of client: _____DOB: _____Race: _____American Indian: yes____ no_____

Adult(s) w/whom client lives: _____

Address: _____Phone: _____

Current weekly fitness routine: _____
_____
_____
_____
_____

Presenting behavioral concerns:_____
_____
_____
_____
_____

Medical conditions/handicaps/medications /Allergies (including meds, bees, sunscreen and inhaler use):
_____
_____
_____

(If accepted, a more formal assessment will be conducted with legal guardian and child)