



# GiGiFIT Infant Physician Approval for Physical Activity Purposeful Programs

Participant's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

GiGi's Playhouse- Down Syndrome Achievement Centers is a non-profit organization which provides free educational and therapeutic programs for individuals with Down syndrome, their families and the community. The individual mentioned above is interested in participating in a program for infants with Down syndrome for pre-walking, called GiGiFIT Infant.

The GiGiFIT Infant program begins the lifelong learning of movements and skills targeting core muscle groups to improve strength, stability, coordination, movement control and communication. This program provides families with activities and strategies to help their child improve posture, rolling, sitting, crawling, balance and movement control. GiGiFIT Infant not only addresses low muscle tone and joint laxity but also is a work-out for the brain and vestibular system. When we address low muscle tone at this age, we are setting our kids up for optimal performance in their future! Recommended for ages birth to pre-walking.

Due to the nature of this program, it is imperative that each participant is in a state of health that is conducive to participation in physical activity. As the physician overseeing the health care of the above mentioned individual, your approval for participation in physical activity is requested. For more information, please contact GiGi's Playhouse at 847-885-7529 or programshoffman@gigisplayhouse.org. Thank you!

Proposed Physical Activities in GiGiFIT Infant: Upon review, please indicate whether you approve your patient to participate in the preceding activities within GiGiFIT Infant:

- Safe Stretching
- GiGiFIT Foundational Movements
- GiGiFIT Mobility Movements
- GiGiFIT Visual and Vestibular Movements
- GiGiFIT Warm-up and Cool Down
- GiGiFIT Primitive Reflex Movements
- Bodyweight exercises

- I approve my patient participating in the proposed physical activities
- I do not approve my patient participating in any of the proposed physical activities
- I approve my patient participating in the proposed physical activities with the following modifications:

\_\_\_\_\_

This individual has (or had surgical correction of) cervical subluxation/atlando-axial instability and should not participate in activities likely to result in a blow to the head or straining of the neck such as wrestling, diving, gymnastics, tumbling, butterfly stroke, or contact sports.

Physician's Name (printed/ stamped): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_