

HEALTHY CARE FOR HEALTHY KIDS MANAGEMENT PLAN

Patient Name: _____

Birth Date: _____

Age: _____

Name of Office/Health Center: _____

Date of Visit: _____

Office/Health Center Phone Number: _____

Provider: _____

Gender: Female Male

BMI % FOR AGE _____

Classification: Under Weight

At risk for overweight

Overweight

SHARED GOALS: IDENTIFIED BY PARENT/CHILD AND PROVIDER

(List one or more goals in the spaces below)

PHYSICAL ACTIVITY GOALS:

Decrease Screen Time: _____

Increase Physical Activity: _____

Participate in a Sports Activity: _____

Other: _____

NUTRITION GOALS:

Increase Fruits and Vegetables: _____

Decrease Sugar-Sweetened Drinks: _____

Decrease Fast Food Meals: _____

Other: _____

EDUCATIONAL HANDOUTS

Written instructional materials (specify tool(s) given) _____

Resource list given Referral to Community Program _____

Other: _____

FOLLOW UP AND REFERRALS

Date for Next Telephone Follow-up: _____ Number to call family at: _____

Date for Next Office Visit: _____ Referral to Community Program _____

Referral for additional medical/nutritional/psychological evaluation/therapy: _____

Comments: _____

Provider Signature: _____ **Parent Signature:** _____

