OUR ACTION PLAN for HEALTHY WEIGHT

Patient Name: ___________________________ Date: ___________________________
Provider: _______________________________

<table>
<thead>
<tr>
<th>WEIGHT CATEGORY (circle one)</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unhealthy  BMI &gt;95%:</td>
<td>The child’s weight is not healthy.</td>
</tr>
<tr>
<td>May be Unhealthy  BMI 85-95%:</td>
<td>The child may be at an unhealthy weight.</td>
</tr>
<tr>
<td>Healthy  BMI 5-84%:</td>
<td>The child’s weight is healthy.</td>
</tr>
<tr>
<td>Underweight  BMI &lt;5%:</td>
<td>The child is at a weight that may not be high enough for best health.</td>
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</tbody>
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GOALS:
How important do you feel it is to make healthy changes in eating or activity? (please circle a number)
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Not important at all                           Most important thing right now

Choose 1-3 goals

**Fruits and Veggies (5)**

- □ Try to eat 5 fruits and vegetables every day - keep track
- □ Fill half of everyone’s plate with fruits and vegetables
- □ Include a fruit or vegetable in every snack
- □ For preschoolers, give a sticker for trying a vegetable
- □ Doing Well

**Less Screen Time (2)**

- □ Limit TV and video games to less than 2 hours a day
- □ Move TV/computer/video games/other screens out of bedrooms
- □ Unplug the family for a week - no TV
- □ Have a child choose 1-2 favorite shows: __________________________
- □ Doing Well

**More Physical Activity (1)**

- □ Play outside 1 hour every day
- □ Go to a park or playground _________ times/week
- □ Join a sports team or rec center
- □ Give kids active chores to help out at home
- □ Doing Well

**No Sweet Beverages (0)**

- □ Together as a family, stop drinking drinks sweetened with sugar
- □ Drink no more than ½ cup (4oz) juice a day
- □ Drink low-fat milk, or fat free after 2 years
- □ Drink more water: _________ glasses/bottles a day
- □ Doing Well

**Other Goals**

**Family Meals**

- □ Eat dinner as a family _________ times/week
- □ Turn TV off during meals and enjoy talking as a family
- □ Parents serve smaller portions of _______________
- □ Eat from restaurants less: _________ times/week
- □ Doing Well

**Breakfast**

- □ Eat breakfast every day
- □ Pick cereals with less than 8 grams sugar and at least 3 grams fiber
- □ Doing Well

**Sleep**

- □ Go to bed earlier at ___________ o’clock
- □ Move TV out of the bedroom
- □ Stop eating after ___________ o’clock
- □ Doing Well

How confident are you that you can make the changes you picked? (please circle a number)
0-----1-----2-----3-----4-----5-----6-----7-----8-----9---------- 10
Not confident at all                            Very confident

Barriers Addressed: ___________________________

Comments: ___________________________

Patient Signature: ___________________________ Guardian Signature: ___________________________

Clinician Signature: ___________________________ Visit Date: ___________________________

Follow up: ___________________________ Stage: (circle) 1 2 3 4

Referral: ___________________________ Phone #: ___________________________