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|----------------|
| Patient Name: |
| DOB: |
| Date of Visit: |
| Provider: |



CARE PLAN FOR A HEALTHY WEIGHT

NUTRITION GOALS

(Fruits & Veg., Sweet drinks, Fast Food, Family meals # meals)

1. I will _____
2. I will _____
3. I will _____
4. I will _____
5. I will _____

ACTIVITY GOALS

(screen time, organized sports, unorganized goals)

1. I will _____
2. I will _____
3. I will _____
4. I will _____
5. I will _____

EDUCATIONAL HANDOUTS

1. _____
2. _____

COMMUNITY RESOURCE LIST

REFERRALS

1. _____
2. _____

FOLLOW-UP

1. _____ Phone
2. _____ Visit

Signature _____ Provider
Signature: _____ Parent/Patient