

SECTION 5

ACTION PLANS

FOR

UNDER & OVER WEIGHT

**LETTER TO PARENTS,
MEDICAL PROVIDER, AND
ACTION PLAN FOR CHILDREN
WITH BMI'S UNDER THE 5TH
PERCENTILE**

Date: _____

Dear Parent/Guardian of _____

Our screening indicates that your child may be underweight or overweight compared to standards established for children their age. We are concerned because being underweight or overweight can be linked to a variety of health risks for children. This needs to be evaluated by a health professional in terms of overall growth and development.

On (date) _____ your child's Height: _____ Weight: _____ BMI: _____

(Body Mass Index (BMI) is a ratio of weight to height and is used to assess how a child is growing)

When graphed, your child's BMI is:

- Greater than the 95th percentile
- Between 85th and 95th percentile
- Under the 5th percentile

Your child will be re-weighed at scheduled times at your Head Start site.

Please follow up:

- Make an appointment with your doctor/medical provider and return the Action Plan form.
- Make appointment with WIC nutritionist.
- Read the attached materials and make healthy lifestyle choices for your family.

If you have any questions or concerns please contact your Head Start Staff.

Sincerely,

Staff Name: _____

Staff Title: _____

Date: _____

Dear Health Care Provider,

Re: Child's Name: _____ Birth Date: _____

Parent/Guardian Name: _____

I am writing to ask your assistance with a child who is enrolled in our program and is your patient. The following are the latest anthropometric measurements that were taken on (date) _____.

Height: _____ Weight: _____ BMI: _____

When graphed, this represents a BMI-for-age of:

- Greater than or equal to 95th percentile
- Under the 5th percentile

Head Start requires that we have documentation of a treatment plan. Your assistance is requested in creating this documented treatment plan.

- Please evaluate and rule out any physiologic or metabolic contributors to their condition.**
- Please fill out the attached Action Plan and return it to the parent or Head Start site.**

The staff of the Head Start site will help to reinforce this plan.

Sincerely,

Staff Name: _____

Staff Title: _____

Medical Providers Action Plan for Underweight

Child's Name: _____ **Birth Date:** _____

Parent/Guardian Name: _____

Is there a metabolic or physiological concern: Yes No

Medical evaluation shows this child to be:

Underweight Overweight Weight Not of Concern at this Time

Intervention

- Referral to WIC
- Pediatric Dietitian/Nutritionist Referral
- Other Referral _____
- Nutritional Supplementation or dietary modification for school (Rx) _____

Dietary Suggestions to Improve Intake

- Manage fluids to improve appetite and food intake:
 - Encourage a gradual change in fluid consumption to approximately 16-24 oz whole milk or other calcium fortified, nutrient dense beverage.
 - Together, juice, fruit drinks and soda should be limited to 4 oz/day.
- Increase energy content of foods/beverages by adding; whole milk, powdered milk, cream, half and half, instant breakfast, avocados, sour cream, soy powders, peanut butter, margarine, oils or yogurt, to food and meals.
- Enjoy Family Meals:
 - Establish routines around mealtimes and snacks (Offer 3 meals and 2 snacks everyday)
 - Be sure to allow children enough time at the table, aim for 20 minutes.
 - Try to make meals stress-free. Avoid lecturing or forcing your child to eat.

Recommendations:

Follow-up Appointment: _____

Provider's Signature: _____ Date: _____

Provider's Name (Printed): _____ Phone: _____

Address: _____

**LETTER TO PARENTS,
AND ACTION PLAN FOR
CHILDREN WITH BMI'S
BETWEEN THE 85TH
AND 95TH
PERCENTILE**

Date: _____

Dear Parent/Guardian of _____

Our screening indicates that your child may be underweight or overweight compared to standards established for children their age. We are concerned because being underweight or overweight may be linked to a variety of health risks for children. This needs to be evaluated in terms of overall growth and development.

On (date) _____ your child's Height: _____ Weight: _____ BMI: _____

(Body Mass Index (BMI) is a ratio of weight to height and is used to assess how a child is growing)

When graphed, your child's BMI is:

- Greater than the 95th percentile
- Between 85th and 95th percentile
- Under the 5th percentile

Your child will be re-weighed at scheduled times at your Head Start site.

Please follow up:

- Make an appointment with your doctor/medical provider for further evaluation and return the Action Plan form to Head Start.
- Make an appointment with a WIC nutritionist.
- Read the attached materials and make healthy lifestyle choices for your family.

If you have any questions or concerns please contact your Head Start Staff.

Sincerely,

Staff Name: _____

Staff Title: _____

Action Plan for Healthy Lifestyle

Child's Name: _____ Birth Date: _____

Parent/Guardian Name: _____

Has the child been referred to WIC?

Yes No

Intervention

- Pediatric Dietitian/Nutritionist Referral
- Other Referral _____

Nutrition

- Offer 3 meals and 2 snacks. Do not skip any meals.
- Offer water throughout the day instead of a high sugar beverage such as soda and fruit
- Provide no more than 4oz or ½ cup of 100% juice each day.
- Offer 16 oz or 2 cups of 2%, 1% or skim milk each day.
- Eat fruit and/or vegetables at each meal and snack (2-3 or more servings of each/day)
- Include salads, fruits and low fat milk when eating out.

Physical Activity

- Exercise, walk, jog, dance or jump rope with your child for 60 minutes at least 5 days/week.
- Encourage "lifestyle" exercise (Suggestions of activities to do with your child: walk to the store, walk the dog, take the stairs, park at the far end of the parking lot, walk to school, do housework).
- _____

Behavior Patterns

- Eat together as a family. Encourage everyone to eat a variety of food groups.
- Limit television/computer/video game time to no more than 1-2 hours each day.
- Turn the television off during mealtime and encourage conversation.
- Reward with attention, not food.
- Eat the way you want your child to eat. You are a role model. Make changes as a family.

Recommendations:

Follow-up Appointment: _____

Provider's Signature: _____ Date: _____

Provider's Name (Printed): _____ Phone: _____

Address _____

**LETTER TO PARENTS,
MEDICAL PROVIDER, AND
ACTION PLAN FOR CHILDREN
WITH BMI'S OVER THE 95TH
PERCENTILE**

Date: _____

Dear Parent/Guardian of _____

Our screening indicates that your child may be underweight or overweight compared to standards established for children their age. We are concerned because being underweight or overweight may be linked to a variety of health risks for children. This needs to be evaluated in terms of overall growth and development by a medical provider.

On (date) _____ your child's Height: _____ Weight: _____ BMI: _____

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Please follow up:

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The staff of the Head Start site will help to reinforce this plan.

Sincerely,

Staff Name: _____

Staff Title: _____

Medical Provider's Action Plan for Healthy Lifestyle

Child's Name: _____ Birth Date: _____

Parent/Guardian Name: _____

Is there a metabolic or physiological concern: Yes No

Medical evaluation shows this child to be:

Obese Overweight Underweight Weight Not of Concern at this Time

Intervention

- Referral to WIC
- Pediatric Dietitian/Nutritionist Referral
- Other Referral _____

Nutrition

- Offer 3 meals and 2 snacks. Do not skip any meals.
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Provider's Signature: _____ Date: _____

Provider's Name (Printed): _____ Phone: _____

Address _____