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
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:
  o Encourage a gradual change in fluid consumption to approximately 16-24 oz whole milk or other calcium fortified, nutrient dense beverage.
  o 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:
  o Establish routines around mealtimes and snacks (Offer 3 meals and 2 snacks everyday)
  o Be sure to allow children enough time at the table, aim for 20 minutes.
  o 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 85<sup>TH</sup> AND 95<sup>TH</sup> PERCENTILE
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: __________

(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 the 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: _________________________________________
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 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.
☐ 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: ____________________________  Date: ______________

Provider’s Signature: ____________________________

Provider’s Name (Printed): ____________________________  Phone: ______________

Address ________________________________________________________________________________