Healthy Weight Assessment/Plan for School Nurses

Initial ☐ Follow-Up ☐

Child Name_____ DOB _____ WT_____HT_____BMI_____ BMI Date_____

School_____ Grade_____ Teacher _____

Parent/Guardian Name _____ Phone_____ Email _____

Physician _____ Physician Phone_____ Physician Fax_____

A. ASSESSING HABITS

1. How many servings of **FRUITS OR VEGETABLES** does you child eat **a day**? _____
2. How many times **a week** does your child **EAT DINNER AT THE TABLE with the FAMILY**? _____
3. How many times **a week** does your child eat **BREAKFAST**? _____
4. How many times **a week** does your child **EAT TAKEOUT or FAST FOOD**? _____
5. How many **hours a day** does your child **watch TV**, or sit and play **video games**? _____
6. Does your child have a **TV IN THE ROOM** where he/she sleeps? Yes No
7. On most days, **how many minutes** does your child spend in ***ACTIVE*** **PLAY**? *(fast breathing, sweating)* _____
8. How many 8 ounce servings of the following does your child **DRINK** a day? *(An 8 ounce serving is the size of one cup)*

100% Juice _____ Fruit/Sports Drink _____ Soda/punch _____

Whole Milk _____ Fat Free/Low Fat Milk _____ Water _____

B. SETTING A GOAL / REVIEWING IDENTIFIED GOAL

Are there goals that you are ready to try?

5 ☐ Eat at least 5 servings of fruits/vegetables a day

2 ☐ Limit screen time *(especially TV)*

1 ☐ Get at least 60 minutes of physical activity every day

0 ☐ Avoid sugar-sweetened drinks *(soda, sports drinks, punch, etc)*

☐ Other _____

_____

_____

_____

C. ACHIEVING MY GOAL

1. How important is it to me to make this change? *(circle a number)*

0	1	2	3	4	5	6	7	8	9	10

Not at all important *Extremely important*

2. What might make it hard to achieve this goal (what are the barriers)?

_____

_____

3. Information or support I might need in accomplishing this goal:

_____

D. TREATMENT PLAN / RESOURCES NEEDED

_____

_____

_____

_____

E. COMMITMENT

Developed by _____ in collaboration with

School Nurse

_____ on _____

Parent / Guardian *Date*