

## Health Promotion Activities Plan

**\*\*This sample is to assist you in developing a health promotion activity plan. It is not intended to replace medical advice. Any instructions given by the physician regarding this diagnosis must be included.**

Name of Individual:

Health Concern/Issue * (Diagnosis)	<b>FETAL ALCOHOL SYNDROME</b>
Related Body System	Vision      Respiratory      Lymphatic      Dental      Hearing      Digestive      Integumentary (Skin)      Endocrine Cardiovascular      Nervous      Musculoskeletal      Genitourinary      Blood <b>Genetic</b>
What is it? (Provide definition)	A group of birth defects caused by drinking alcohol during pregnancy
Signs and Symptoms (general)	Different levels of mental retardation, facial deformities, bone, joint, and limb deformities, poor fine motor skills, muscle tremors or rigidity, short stature, increased risk for depression, antisocial and/or criminal behaviors, increased risk of ADHD and/or autistic-like behaviors, hearing and/or vision problems, increased risk of heart, kidney disease.
Signs and Symptoms (specific to the person):	
Promotion/strategy support required * List very specific steps that the individual and/or caregivers use to support the person's health condition.  Include information about monitoring health status. Who is called for changes/ problems in this person's health condition?  What is tracked, where it can be found, and who follows up on documentation required for this health condition?  Who provides what training for the person and staff about the health condition and when?	<ul style="list-style-type: none"> <li>➤ Observe for an increase in, or a change in signs and symptoms as above. Report any changes to <u>(title of person in agency who is responsible to receive this information)</u>.</li> <li>➤ <u>Include any specific instructions regarding this diagnosis from the treating physician.</u></li> <li>➤ Provide routine and a structured environment</li> <li>➤ Documentation about this condition can be found in the medical record under <u>(list section here)</u>.</li> <li>➤ Receive training regarding this diagnosis and plan of care (include when to notify the physician) by <u>(title of person who provides medical training)</u> at least <u>(indicate frequency of training)</u> or as changes occur. This should be documented for all staff in the home.</li> </ul>
Frequency of support *	<i>Fill in what physician (e.g. primary care physician) evaluates this condition and how often the person is seen.</i>
Desired outcome *	Any changes in physical or mental status will be noted and evaluated
Person/agency responsible *	<u>(Name of person)</u> , caregivers, agency nurse, primary care physician, <u>(specialist, if applicable)</u> <i>(The responsible parties may vary according to your agency; please place specific roles in this section. Some other examples might be health care coordinator, program specialist, house manager.)</i>

\* FIELDS FOUND IN THE HEALTH PROMOTION SECTION OF THE ISP