**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)

<table>
<thead>
<tr>
<th>Related Body System</th>
<th>Vision</th>
<th>Respiratory</th>
<th>Lymphatic</th>
<th>Dental</th>
<th>Hearing</th>
<th>Digestive</th>
<th>Integumentary (Skin)</th>
<th>Endocrine</th>
<th>Cardiovascular</th>
<th>Nervous</th>
<th>Musculoskeletal</th>
<th>Genitourinary</th>
<th>Blood</th>
</tr>
</thead>
</table>

### What is it? *(Provide definition)*

A recurring, severe, headache which may last from hours to days. This could be caused due to widening of the blood vessels in the brain or disturbances of nerve pathways.

### Signs and Symptoms *(general)*

Symptoms may include severe pain located on one side of the head with sensitivity to light, nausea and vomiting. Visual disturbance ("aura") may be the first symptom of an oncoming episode.

### Signs and Symptoms *(specific to the person)*

- Watch *(name of person)* for signs and symptoms listed above and report immediately to *(title of person in agency who is responsible to receive this information).*
- Give medication as ordered (see Medication Administration Record/Log). If a prn (as needed) medication is given, the result must be documented per agency policy.
- *Include any specific instructions from the treating physician.* For example, periods of rest in a quiet, calm dark environment, keep head slightly elevated, etc.
- Ensure that *(name of person)* receives diet recommended by physician *(list diet here).*
- Documentation about this condition can be found in the medical record under *(list section here).*
- Receive training regarding this diagnosis and plan of care (include when to notify the physician) by *(title of person who provides medical training)* at least *(indicate frequency of training)* or as changes occur. This should be documented for all staff in the home.

### Frequency of support *

**Fill in what physician (e.g. primary care physician, neurologist) treats this condition and how often the person is seen.**

### Desired outcome *

To recognize symptoms as soon as possible to obtain treatment.

**Person/agency responsible **

*(Name of person), caregivers, agency nurse, primary care physician, *(specialist, if applicable)*

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