**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: [Name]

### Health Concern/Issue *
- **(Diagnosis)** MYOPIA (Nearsightedness)

<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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Endocrine</td>
<td>Cardiovascular</td>
<td>Nervous</td>
<td>Musculoskeletal</td>
<td>Genitourinary</td>
<td>Blood</td>
<td></td>
</tr>
</tbody>
</table>

What is it? *(Provide definition)*

Myopia (alternative names are Nearsightedness and Shortsightedness) is an error of visual focusing that makes distant objects appear blurred.

Signs and Symptoms *(general)*

- Blurred vision or squinting when trying to see distant objects, eyestrain, headaches.

**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?

- 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)*.

- Clean glasses daily or as needed.

- 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. ophthalmologist) treats this condition and how often the person is seen.

### Desired outcome *

- To recognize symptoms as soon as possible to obtain treatment; to maintain clear vision.

### Person/agency responsible *

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