Wellmark

Adolescent Health

My Prescription for You

Name ______________________ Age __________ Date ______________

Immunizations

			Due
Hepatitis B Series - Completed	❑ Yes	or ❑ No	________
1st Hep B	❑ Yes	or ❑ No	________
2nd Hep B (4 weeks after 1st)	❑ Yes	or ❑ No	________
3rd Hep B (8 weeks after 2nd)	❑ Yes	or ❑ No	________
Tetanus Booster (Tdap) (between ages 11-12)	❑ Yes	or ❑ No	________
MMR (by age 11-12) Completed	❑ Yes	or ❑ No	________
Flu Vaccine Discussed/Given?	❑ Yes	or ❑ No	________
HPV Series (Ages 11-18) - Completed	❑ Yes	or ❑ No	________
1st HPV	❑ Yes	or ❑ No	________
2nd HPV (4 weeks after 1st)	❑ Yes	or ❑ No	________
3rd HPV (8 weeks after 2nd)	❑ Yes	or ❑ No	________
Meningococcal (between ages 11-12)	❑ Yes	or ❑ No	________

Weight Management

Today's Height and Weight ____________ Today's BMI ____________

Desired Weight ____________ Desired BMI ____________

Counseling Discussed Today

- ❑ Tobacco
- ❑ Alcohol
- ❑ Substance Abuse
- ❑ Sexual Health
- ❑ Eating Disorders
- ❑ Injury Prevention
- ❑ Violence/Anger Management
- ❑ Self Esteem
- ❑ Piercings
- ❑ Peer Pressure
- ❑ Tattoos

Nutrition

I would like you to: ______________________________

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Resources

U.S. Dept. of Health and Human Services
www.girlshealth.gov/nutrition

Food and Nutrition Information Center
www.usda.gov

Activity

I would like you to: ______________________________

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Resources

Centers for Disease Control and Prevention
www.cdc.gov/physicalactivity/everyone

U.S. Dept. of Health and Human Services
www.smallstep.gov

Provider Signature ______________________________ Date ______________

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