
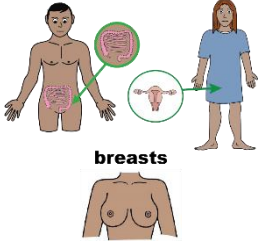
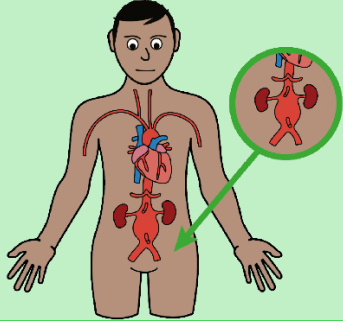
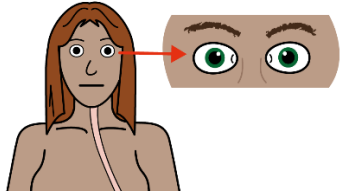




# My Health Action Plan

Name:		Date of Birth:		Date:	
Health Need	When did the issue start?	Goal	Action	Who can help me?	When do we look at this again?
1. <b>eyes</b> 					
2. <b>Ears</b> 					
3. <b>teeth</b> 					

# My Health Action Plan

<p>4. <b>vaccines</b></p> 					
<p>5. <b>Screening</b> bowel cervical breasts</p> 					
<p>6. <b>Abdominal Aortic Aneurysm</b></p> 					
<p>7. <b>Diabetic eye check</b></p> 					

# My Health Action Plan

8.					
9.					
10.					
11.					