LHSA

A Community Action Agency

HEAD START NUTRITION ASSESSMENT

To Be Completed/Reviewed/Updated by Head Start Parent/Guardian Each Year

CHILD'S NAME: _____ **DATE:** _____

	1st Year		2nd Year		
	Yes	**No**	**Yes**	**No**	
1. Does child currently have any medically diagnosed food allergies/intolerances?					What kind?
2. Is child currently on medical diet? Doctor's prescription needed before special diet can be given.					What kind?
3. Are there any foods not eaten for religious or cultural reasons?					What kind?
4. Are there disabilities or medical/dental problems currently affecting eating?					Please describe:
5. Does child currently have eating-related problems with: **chewing ___ swallowing ___** **gagging ___ throwing up ___**					Please describe:
6. Does child currently eat non-food things? (dirt, paper, paint chips, crayons)?					Please describe:
7. **Does child currently drink from a bottle or sippy cup?**					What liquids?
8. Does child take vitamins, mineral supplements or herbal supplements?					What kind?
9. Was the supplement prescribed by doctor?					

10. What kind of appetite does your child have:	**1st Year: (circle)**	Good	Fair	Poor		
	2nd Year: (circle)	Good	Fair	Poor		
11. Circle any of the foods your child does **NOT** eat:	**1st Year: (circle)**	Grains	Vegetables	Fruit	Milk	Meats
	2nd Year: (circle)	Grains	Vegetables	Fruit	Milk	Meats
12. Describe your child's weight:	**1st Year: (circle)**	Over	Average	Under		
	2nd Year: (circle)	Over	Average	Under		

13. Are there any nutrition-related concerns (such as feeding your preschooler, healthy snacks for children, picky eaters, healthy weight, diabetes, high blood pressure, location of food pantries, etc*) that you would you like to speak with the Head Start dietitian about? **Yes** **No**

**Information is available on these topics at your Head Start Center*

Additional nutrition information can be found at the following websites:

www.EatRight.org

www.ChooseMyPlate.gov

1st Year Child is receiving WIC Services Yes____ No____ **2nd Year** Child is receiving WIC Services Yes____ No____

1st Year Parent Signature: _____ **Date:** _____

2nd Year Parent Signature: _____ **Date:** _____

Reviewed by staff 1st Year: _____ **Date:** _____

Reviewed by staff 2nd Year: _____ **Date** _____

NOTE: If 'Yes' for #1 –#7 or #13, or if not receiving WIC services referral to Head Start dietitian must be made