



GRISWOLD ELEMENTARY SCHOOL

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NUTRITION QUESTIONNAIRE FOR CHILDREN

(Adapted from Bright Futures in Practice: Nutrition, Appendix B, pgs. 232-236,
National Center for Education in Maternal and Child Health, 2000)

Student Name: _____

This nutrition questionnaire is a tool for parents/guardians to complete before meeting with child care staff members (e.g., health or education professionals, family day-care providers). The questionnaire provides a useful starting point for identifying areas of nutrition concern and the need for additional screening. Please let us know if your family would benefit from modifications to this form to best meet cultural needs, and contact your child's teacher with any questions or concerns.

1. How would you describe your child's appetite? (check one) ☐ Good ☐ Fair ☐ Poor ☐ Picky

2. How many days per week does your family usually eat meals together? _____

3. How would you describe mealtimes with your child? (check one)

☐ Always Pleasant ☐ Usually Pleasant ☐ Sometimes Pleasant ☐ Never Pleasant

4. How many meals does your child usually eat per day? _____

5. How many snacks does your child usually eat per day? _____

6. Which of these foods did your child eat or drink in the last week? (check all that apply)

Grains	Vegetables	Fruits
<input type="checkbox"/> Bagel	<input type="checkbox"/> Broccoli	<input type="checkbox"/> Apple/Juice
<input type="checkbox"/> Bread	<input type="checkbox"/> Carrots	<input type="checkbox"/> Banana
<input type="checkbox"/> Cereal/Grits	<input type="checkbox"/> Corn	<input type="checkbox"/> Berries
<input type="checkbox"/> Crackers	<input type="checkbox"/> French Fries	<input type="checkbox"/> Grapefruit/Juice
<input type="checkbox"/> Muffin	<input type="checkbox"/> Green Beans	<input type="checkbox"/> Grapes/Juice
<input type="checkbox"/> Noodles/Pasta	<input type="checkbox"/> Green Salad	<input type="checkbox"/> Melon
<input type="checkbox"/> Rice	<input type="checkbox"/> Greens (collard, spinach)	<input type="checkbox"/> Orange/Juice
<input type="checkbox"/> Rolls	<input type="checkbox"/> Peas	<input type="checkbox"/> Peaches
<input type="checkbox"/> Tortillas	<input type="checkbox"/> Potatoes	<input type="checkbox"/> Pears
<input type="checkbox"/> Other Grains:	<input type="checkbox"/> Tomatoes	<input type="checkbox"/> Other Fruits/Juice:
_____	<input type="checkbox"/> Other Vegetables:	_____
_____	_____	_____



GRISWOLD EARLY EDUCATION PROGRAM NUTRITION QUESTIONNAIRE FOR CHILDREN

Milk & Dairy Products <ul style="list-style-type: none"><input type="checkbox"/> Whole Milk<input type="checkbox"/> 2% Milk (reduced fat)<input type="checkbox"/> 1% Milk (low-fat)<input type="checkbox"/> Skim Milk (non-fat)<input type="checkbox"/> Chocolate Milk<input type="checkbox"/> Cheese<input type="checkbox"/> Ice Cream<input type="checkbox"/> Yogurt<input type="checkbox"/> Other Milk/Dairy Products: _____ _____ _____	Meat & Meat Alternatives <ul style="list-style-type: none"><input type="checkbox"/> Beef/Hamburger<input type="checkbox"/> Chicken<input type="checkbox"/> Cold Cuts/Lunchmeat<input type="checkbox"/> Dried Beans<input type="checkbox"/> Eggs<input type="checkbox"/> Fish<input type="checkbox"/> Peanut Butter/Nuts<input type="checkbox"/> Pork<input type="checkbox"/> Sausage/Bacon<input type="checkbox"/> Tofu<input type="checkbox"/> Other Sources of Protein: _____	Fats & Sweets <ul style="list-style-type: none"><input type="checkbox"/> Cake/Cupcakes<input type="checkbox"/> Candy<input type="checkbox"/> Chips<input type="checkbox"/> Cookies<input type="checkbox"/> Doughnuts<input type="checkbox"/> Fruit-flavored drinks<input type="checkbox"/> Kool-Aid<input type="checkbox"/> Pie<input type="checkbox"/> Soft Drinks (soda)<input type="checkbox"/> Other fats & sweets: _____ _____
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7. Does your child eat any of these foods? (check all that apply)

<ul style="list-style-type: none"><input type="checkbox"/> Hot Dogs<input type="checkbox"/> Marshmallows<input type="checkbox"/> Nuts & Seeds	<ul style="list-style-type: none"><input type="checkbox"/> Popcorn<input type="checkbox"/> Pretzels & Chips<input type="checkbox"/> Raisins<input type="checkbox"/> Peanut Butter	<ul style="list-style-type: none"><input type="checkbox"/> Raw Celery or Carrots<input type="checkbox"/> Round or Hard Candy<input type="checkbox"/> Whole Grapes
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8. How many servings of 100 percent juice (for example, orange, apple or grape juice) does your child drink per day? _____

9. How many servings of sweetened beverages (for example, Kool-Aid, fruit punch and soft drinks) does your child drink per day? _____

10. Does your child drink water that is fluorinated or take a fluoride supplement?

☐ Yes ☐ No ☐ Don't know

11. Does your child take a bottle to bed at night or carry a bottle or sippy cup around during the day? ☐ Yes ☐ No

12. Do you have a working stove, oven, and refrigerator where you live? ☐ Yes ☐ No

13. Were there any days last month when your family didn't have enough food to eat or enough money to buy food? ☐ Yes ☐ No

14. Does your child have more than two (2) hours of screen time per day? ☐ Yes ☐ No

15. What concerns or questions do you have about feeding your child? _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

For Internal Use: Teacher: _____ ☐ AM ☐ PM