Absaroka Head Start
Nutrition Screening Form
Program Year 2015 / 2016

Last Name	First Name	Middle Name	Date of Birth	Gender
			/ /	☐ M ☐ F

Question			Comments/Descriptions
Does your child need any special diet modifications for health reasons, i.e. diagnosed food allergies or due to a disability?	☐ No	☐ Yes	**IF YES**, a Special Care Plan **MUST BE IN PLACE** before your child begins classroom services.
If YES, What? Accommodation / Substitution:			
Are there any foods you do not want your child to eat for cultural, religious or personal reasons?	☐ No	☐ Yes	**IF YES**, a Special Care Plan **MUST BE IN PLACE** before your child begins classroom services.
If YES, What? Accommodation / Substitution:			
How would you describe your **child's appetite**? ☐ Good ☐ Fair ☐ Poor			
Does your child have difficulty self-feeding, chewing or swallowing? ☐ No ☐ Yes If Yes, please describe. Do you have any concerns or questions about your child's **appetite or eating**? ☐ No ☐ Yes If Yes, please describe. If yes, would you like to meet with a nutritionist? ☐ No ☐ Yes			
How many **DAYS** does your family eat meals together **each week**?			
I would describe most **MEAL TIMES** with my child as: ☐ Wonderful ☐ Good ☐ Just OK ☐ A Challenge			
How many **MEALS** does your child eat **each day**? How many **SNACKS?**			
Do you have any concerns about your child's **growth or weight**? ☐ No ☐ Yes If Yes, please describe.			
How much **JUICE** does your child drink **each day**? How much **SWEETENED BEVERAGE** (Kool Aid, boxed drink, soft drinks) does your child drink **each day**?			
Does your child take **a bottle to bed** at night/nap or **carry a bottle around** during the day? ☐ No ☐ Yes If Yes, please describe.			
What is the **SOURCE OF THE WATER** that your child drinks? ☐ Public (tap water) ☐ Commercially bottled ☐ Home Filtered ☐ Other:			
Does your child spend more than **2 hours PER DAY** watching television and videotapes and/or playing computer games? ☐ No ☐ Yes If Yes, please describe.			
Does your child **TAKE** any of the following? ☐ Vitamin Supplements ☐ Iron Supplements ☐ Fluoride			
Does your family need assistance with **food resources**? ☐ No ☐ Yes Do you obtain food resources from the Food Bank? ☐ No ☐ Yes Do you receive WIC? ☐ No ☐ Yes Do you receive Food Stamps / SNAP? ☐ No ☐ Yes			

What are your child's **FAVORITE FOODS**?

What foods will your child **NOT EAT**?

Signature of Parent/Legal Guardian Date

Staff Signature Date

Revised: 3/26/15