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

CHILD'S NAME: _____

	1st Year		2nd Year		
	Yes	**No**	**Yes**	**No**	
Does child currently have any medically diagnosed food allergies/intolerances?					What kind?
Is child currently on medical diet? Doctor's prescription needed before special diet can be given.					What kind?
Are there any foods not eaten for religious reasons?					What kind?
Are there disabilities or medical/dental problems currently affecting eating?					Please describe:
Does child currently have eating-related problems with: chewing_____swallowing_____ gagging_____throwing up_____					Please describe:
Does child currently eat non-food things? (dirt, paper, paint chips, crayons)?					Please describe:
Does child currently drink from a bottle or sippy cup?					What liquids?
Does child take vitamins, mineral supplements or herbal supplements?					What kind? Prescribed by doctor? [ ] Yes [ ] No
Is your child a picky eater?					

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

What are some of your child's favorite foods? _____

What are some of your child's least favorite foods? _____

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_____

Parent Signature: _____ Date:_____

Reviewed by staff 1st Year: _____Date:_____

Reviewed by staff 2nd Year: _____Date: _____

Reviewed by staff 3rd Year: _____Date: _____