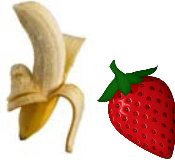
BTHS INC. NUTRITIONAL SCREENING

CHILD'S NAME: ________________________ **BIRTH DATE:** ______________ **DATE:** ________________



	Yes	No
1. Does your child take vitamin and mineral supplements?	☐	☐
a. If "yes", what kind are they: ___________________________________		
b. Do they contain iron?	☐	☐
c. Do they contain fluoride?	☐	☐
d. Were they prescribed?	☐	☐
e. Does your drinking water contain fluoride?	☐	☐
2. Is there any food your child should not eat for religious or personal reasons?	☐	☐
a. What food? ___________________________________		
3. Does your child have any food allergies?	☐	☐
a. What food? ___________________________________		
b. What is the allergic reaction? ___________________________________		
c. Has the allergy been diagnosed by a Health Care Provider? *(If so, an Individual Health Plan, signed by the physician is required by Head Start)*	☐	☐

	Yes	No
4. Is your child on a special diet other than food allergies? (example: tube feeding, pureed food)	☐	☐
a. What kind?_________________________		
b. Was this diet ordered by a Health Care Provider? *(If so, an individual Health Plan, signed by the physician is required by Head Start)*	☐	☐
5. Does your child take a bottle?	☐	☐
6. Does your child eat or chew things that aren't food?	☐	☐
7. Does your child have trouble chewing or swallowing?	☐	☐
8. Do you have any concerns about your child's eating habits? If so, explain _____________________ _________________________________	☐	☐
9. Does your child have digestive problems?	☐	☐
If so, explain___________________________ ___________________________________		
10. Does your child receive WIC?	☐	☐
If not, would you like to receive information about WIC?	☐	☐

11. Approximately how many times per week does your child eat a food from each of the following groups?

a. Milk, cheese, yogurt. 0* 1* 2* 3 4 5 6 7 7+

b. Meat, poultry, fish, eggs; or dried beans/peas, peanut butter. 0* 1* 2* 3 4 5 6 7 7+

c. Rice, grits, bread, cereal, tortillas. 0* 1* 2* 3 4 5 6 7 7+

d. Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes. 0* 1* 2 3 4 5 6 7 7+

e. Oranges, grapefruit, tomatoes, 100% fruit juice. 0* 1* 2* 3 4 5 6 7 7+

f. Other fruits and vegetables. 0* 1* 2 3 4 5 6 7 7+

g. Oil, butter, margarine, lard. 0* 1* 2 3 4 5 6 7 7+*

h. Cakes, cookies, sodas, fruit drinks, candy 0 1 2 3 4 5 6 7 7+*

PARENT COMMENTS:

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FAMILY ADVOCATE/TEACHER COMMENTS/FOLLOW UP *include date(s) when follow up occurred*

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NUTRITION COORDINATOR COMMENTS/FOLLOW UP: *include date screening was reviewed*

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