Alachua County Public Schools
Early Intervention Services
Head Start Program
Nutritional Needs Assessment

Health Staff Complete
Site:____________________
Classroom:________________

Child's Name: ____ Child's Birth Date:_________________

Parent/Guardian (Print): ___________________________________ Phone #: ________________________

Please answer the following questions relating to your child and families eating habits:

1. How would you describe your child's appetite? (check) ☐ Good ☐ Fair ☐ Poor
2. Has your child been diagnosed with ☐ Anemia ☐ Diabetes ☐ PKU ☐ Other_____________ ☐ **N/A**
3. Is your child on a special diet? ☐ Yes ☐ No If yes, what kind?________________________________
4. Are there any foods your child should not eat for medical reasons? ☐ Yes ☐ No
   If yes, please list:____
5. Are there any foods your child should not eat for religious-based reasons? ☐ Yes ☐ No
   If yes, please list:____

***Diet modifications will not begin until proper documentation is provided.**

6. Does your child require special assistance or equipment at meal and snack times? ☐ Yes ☐ No
   If yes, please explain: ____
7. Which of these foods does your child eat? Check all that apply:

☐ milk	☐ cheese	☐ yogurt	☐ meat	☐ poultry	☐ fish	☐ eggs	☐ dried beans/peas
☐ bread	☐ cereal	☐ crackers	☐ rice	☐ pasta	☐ muffins	☐ rolls	☐ peanut butter
☐ apples	☐ bananas	☐ oranges	☐ pears,	☐ cantaloupe	☐ grapefruit	☐ strawberries	☐ broccoli
☐ cabbage	☐ carrots	☐ cauliflower	☐ greens	☐ spinach	☐ sweet potatoes	☐ tomatoes	☐ yams

8. Are there any foods that you think your child isn't eating enough of? ☐ Yes ☐ No
   If yes, list:____
9. Head Start encourages us to consider our families' cultural and ethnic background when planning meals and snacks. We would be delighted for you to share this information to assist us. *Our family's cultural/ethnic background is:*
10. Do you believe your child is ☐ small for age ☐ too thin ☐ too heavy ☐ average
11. Do you have questions about your child's eating habits? ☐ Yes ☐ No
    If yes, what are they?____
12. Does your child frequently choke or gag on food? ☐ Yes ☐ No
    If yes, list:____
13. Are you pregnant at this time? ☐ Yes ☐ No ☐ N/A
14. Do you receive the following: ☐ Food Stamps ☐ WIC ☐ Other food subsidy programs ☐ **N/A**
15. Is/are there any other medical problem(s) with which your child has been diagnosed? ☐ Yes ☐ No
    If yes, please describe:____
16. Does your child eat breakfast before coming to school? ☐ Yes ☐ No
17. At mealtimes, how often does your child eat the same foods as the rest of the family (Check one)
    ☐ Most of the time ☐ Sometimes ☐ Rarely
    If rarely, what does your child eat? List:____

Child's Name ___________________________

18. How often do you sit and eat as a family: ☐ daily ☐ 1-4 days a week ☐ 5-7 day a week

19. How many meals does your child eat most days? _________ How many snacks? _________

20. How are most foods prepared at home? Check all that apply.
☐ Baked ☐ Fried ☐ Roasted ☐ Broiled
☐ Grilled ☐ Microwaved ☐ Boiled

21. Does your child take any vitamins, minerals, herbs or herbal supplements? ☐ Yes ☐ No
If yes, check type: ☐ Children's multivitamin ☐ Iron supplement ☐ Fluoride supplement
☐ Herbal supplement ☐ Vitamin D ☐ Other (list):_____________________________________

22. Check all the ways your child feeds him/herself: ☐ Cup ☐ Fingers ☐ Spoon ☐ Fork

23. Check any of the following your child eats: ☐ Dirt ☐ Clay ☐ Peeling Paint ☐ Newspaper ☐ N/A

24. Does your child drink milk? ☐ Yes ☐ No Check all the types of milk your child drinks:
☐ Whole ☐ 2% ☐ 1% ☐ Skim
☐ Evaporated ☐ Condensed ☐ Lactose Reduced ☐ Lactose Free
☐ Goat's Milk ☐ Soy Milk ☐ Rice Milk ☐ Other:

***** Head Start School Meal program requires that milk is a part of each meal. A doctor's documentation of milk allergy or lactose intolerance is required in order to substitute with any other beverage in your child's meal.***

25. Check all that you have in working order: ☐ Stove ☐ Refrigerator ☐ Sink ☐ Microwave

26. Please check any of the topics that interest you:
☐ Making nutritious snacks and avoiding junk foods ☐ WIC Program
☐ Alternate diets for diabetes and high blood pressure ☐ Food sanitation and storage
☐ Preserving foods by canning, freezing and/or drying ☐ Encouraging positive eating habits
☐ Gainesville Harvest, other food assistance programs ☐ Holiday cooking

Comments/Special Concerns:

____ _________________________
Parent/Guardian Signature *Date*

Distribution: ___ Central File
___ Classroom