

BBNA Head Start

PO Box 310 Dillingham, AK 99576
907-842-4059

NUTRITION HISTORY

CHILDS NAME: _____ BIRTH DATE: ____ / ____ / ____ COMMUNITY: _____

How often does your child eat a food from each of the following groups? Approximate number of times per day (circle number that matches most accurate response)	
a. Milk, cheese, yogurt	0 1 2 3 4 5 6+
b. Fish soup, smelt, dry fish	0 1 2 3 4 5 6+
c. Meat/game, poultry, fish, eggs, peanut butter, nuts, dried beans	0 1 2 3 4 5 6+
d. Rice, bread, cereal, oatmeal, pilot bread	0 1 2 3 4 5 6+
e. Greens, broccoli, carrots, squash, pumpkin, sweet potatoes	0 1 2 3 4 5 6+
f. Oranges, grapefruit, tomatoes (fruit/juice)	0 1 2 3 4 5 6+
g. Other fruits and vegetables	0 1 2 3 4 5 6+
h. Oil, butter, margarine, lard	0 1 2 3 4 5 6+
i. Cakes, cookies, fry bread	0 1 2 3 4 5 6+
j. fruit drinks, tang, soda pop, candy	0 1 2 3 4 5 6+
k. Water	0 1 2 3 4 5 6+
Is the child currently receiving: (If yes, include length of time receiving fluoride)	
a. Topical Fluoride Application	<input type="checkbox"/> Yes <input type="checkbox"/> No Since:
b. Fluoridated Water	<input type="checkbox"/> Yes <input type="checkbox"/> No Since:
c. Fluoride Supplement (tablets, liquid)	<input type="checkbox"/> Yes <input type="checkbox"/> No Since:
Supplements	
Does your child take vitamin and mineral supplements? If yes are they: <input type="checkbox"/> Vitamins with iron <input type="checkbox"/> Vitamins without iron <input type="checkbox"/> Vitamins with fluoride <input type="checkbox"/> Iron supplement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were they prescribed for your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's Food Information	
Does your child have any known food allergies? (If yes, please submit documentation from you Health Care Provider)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:
Are there any foods your child should not eat due to religious beliefs or other reasons?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list:
Is your child on a special diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
Does your child nurse or take a bottle?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
Does your child eat or chew things that are not food? (dirt, clay, paint chips)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
Does your child have difficulty chewing or swallowing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child drink caffeine-containing drinks such as Pepsi or coffee two or more times a day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What, if any, concerns do you have regarding your child's eating patterns?	Concerns:
What time does your child usually eat? (please mark all that apply)	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Snack <input type="checkbox"/> Dinner
Are you currently receiving WIC services?	
<input type="checkbox"/> Yes: How long have you been enrolled in WIC?	_____ Years _____ Months
<input type="checkbox"/> No: Would you be interested in receiving information about WIC?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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FOOD ALLERGIES AND FOOD-RELATED PROBLEMS

For special dietary needs or medical issues, substitute foods may be provided to a child who is unable to consume foods required by the Head Start meal pattern guidelines. *However, food substitutions can be provided only when supported by a written, dated statement from a recognized medical authority (doctor or community health aide.) Written statement must include the recommended food/beverage substitution, and the length of time food/beverage substitution is to be provided.*

If your child has any known food allergies, please submit written documentation by your Health Care Provider to Head Start *immediately*. Help us keep all children healthy!

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____