Tri-County Head Start/Early Head Start

Nutrition and Menu Survey

Child's Name _____ Center _____

Is there anything you would like to share about your child's food likes/dislikes, your family eating patterns, and/or any cultural food preferences you have? _____

_____

_____

Does your child take vitamins?	Y	N	If yes, what kind?
Is there any food your child should not eat for medical or religious reasons?	Y	N	If yes, what kind?
Is your child on a special diet?	Y	N	If yes, what kind?
Does your child have trouble chewing or swallowing?	Y	N	If yes, explain.
Does your child take a bottle?	Y	N	If yes, what kind?
Does your child use formula?	Y	N	If yes, what kind?
Do you have any concerns about what your child eats?	Y	N	If yes, explain.
Does your child have any food allergies?	Y	N	If yes, what kind?
Are you interested in nutritional counseling?	Y	N	
Does your child use a pacifier?	Y	N	If yes, when is it needed.

Comments _____

_____

_____ _____

Parent/Guardian Signature Staff Signature

(For staff use only)

Is follow-up required? □ Yes, (health care plan or modified meal form in file) □ No

_____

School Year