

MYCAP HEAD START/EARLY HEAD START
Early Head Start/Head Start Nutrition Assessment
Ages 1 – 5 years old

Child's Name: _____	Age: _____	DOB: ____/____/____	<input type="checkbox"/> M	<input type="checkbox"/> F
Parent's Name: _____	Daytime Phone: (____) _____			

Check all that apply:

On a typical day; PLEASE CHECK the boxes for the meals your child eats:

- Breakfast Lunch Snack Dinner

1. What does your child typically eat for the following meals, please include beverages:

Breakfast: _____

Lunch: _____

Snack: _____

Dinner: _____

2. Does your child drink Milk? YES NO

If yes, please check the type of milk does your child drink:

- Whole Reduce Fat Flavored

3. Does your child drink from a bottle? YES NO

If yes, please explain: _____

4. Do you feel your child eats Balanced Meals, three meals and a snack? YES NO

If no, please explain: _____

5. Is your child participating in any Nutrition Programs? YES NO

If yes, check which one you are participating in:

- Food Stamps WIC

6. Do you have any Nutrition Concerns YES NO

If yes, please explain: _____

Dietitian Signature

Date