Guam Head Start Program
Nutrition Profile

CHILD'S NAME: _____**Center:**_____ **Application #:**_____

CHILD'S GROWTH INFORMATION	YES	NO
BODY SHAPE HAS CHANGED OVER THE PAST FEW MONTHS ___ MORE SLIM ___ MORE HEAVY		
CHILD'S EATING PATTERN	**YES**	**NO**
EATS _____ MEALS A DAY EATS _____ SNACKS A DAY		
EATS BETWEEN MEALS		
ENJOYS EATING MEALS AND SNACKS		
ALLOWED TO CHOOSE: ___ WHETHER OR NOT TO EAT ___ HOW MUCH TO EAT ___ WHAT TO EAT		
NEW FOODS: REACTION TO NEW FOOD: ___ ACCEPTS ___ IFFY ___ REFUSES RECENT NEW FOOD: _____ CHILD'S REACTION:_____		
NEW FOODS ARE OFFERED WITH FAMILIAR FOOD		
DIET: EATS MILK, CHEESE, OR YOGURT – _____ TIMES A DAY		
EATS VEGETABLES – _____ TIMES A DAY		
EATS FRUITS – _____ TIMES A DAY		
EATS MEAT, FISH, EGGS, OR PEANUT BUTTER (PROTEIN) – _____ TIMES A DAY		
EATS RICE, BREAD, CEREAL, ETC. (GRAINS) – _____ TIMES A DAY		
EATS BUTTER, MARGARINE, COOKING OILS (FRIED FOOD) – _____ TIMES A DAY		
EATS DIRT OR OTHER OBJECTS THAT ARE NOT FOOD – DESCRIBE_____		
DRINKS: _____# OF GLASSES OF WATER A DAY _____# OF GLASSES OF SODA OR TEA A DAY _____# OF GLASSES OF JUICE A DAY – 100% JUICE: ___ YES ___ NO		
FEEDING SKILLS: ___ ABLE TO FEED SELF ___ CHEWS FOOD WELL **USES:** ___ SPOON ___ FORK ___ KNIFE ___ FINGERS ___ OPEN CUP ___ SIPPY CUP ___ BOTTLE ___ STRAW		
IS CHILD ALLERGIC TO ANY FOOD? IF "YES," SPECIFY WHICH FOOD:_____ **Submit doctor's note for any allergies* **ALLERGIC REACTION:** ___ RASH ___ ITCHING ___ SWELLING ___ SNEEZING ___ DIFFICULTY BREATHING		
DOES CHILD REQUIRE A **SPECIAL DIET**? IF "YES," SPECIFY:_____ **Submit "Request for Special Meal Accommodation due to Medical Condition" form completed by Physician*		

DOES YOUR CHILD TAKE VITAMINS? IF "YES" SPECIFY WHAT KIND:_____	☐	☐
HYGIENE: WASHES HANDS BEFORE EATING OR TOUCHING FOOD	☐	☐
FAMILY MEAL AND SNACK PRACTICES	**YES**	**NO**
FAMILY EATS TOGETHER AT A TABLE - IF "NO," OTHER PRACTICE_____	☐	☐
CONVERSATION IS ALLOWED DURING MEALS	☐	☐
DISTRACTIONS ARE KEPT TO A MINIMUM (TV, TOYS, PHONE, ETC.)	☐	☐
WANDERING OR PLAYING IS ALLOWED AT THE TABLE OR DURING MEALS	☐	☐
PARENTS /ADULTS: ☐ EAT MEALS WITH KIDS ☐ EAT SNACKS WITH KIDS ☐ EAT SAME MEALS AS KIDS	☐	☐
PARENTS /ADULTS USE FOOD AS A REWARD AND/OR PUNISHMENT	☐	☐
FAMILY EATS AT HOME	☐	☐
FAMILY EATS AT RELATIVE'S HOUSE (GRANDMA, AUNT, ETC.) _____ TIMES A WEEK	☐	☐
FAMILY EATS OUT _____TIMES A WEEK FAVORITE PLACE TO EAT:_____	☐	☐
DENTAL CARE	**YES**	**NO**
BRUSHES TEETH _____ TIMES A DAY WHEN? _____ ☐ BY SELF ☐ DOES NOT BRUSH TEETH AT ALL ☐ NEEDS HELP ☐ BY PARENT OR OTHER ADULT	☐	☐
HAS HAD FLUORIDE VARNISH TREATMENT – IF "YES," DATE OF LAST TREATMENT:_____	☐	☐

MY CHILD'S FAVORITE FOODS ARE:_____

_____

MY CHILD DOES NOT LIKE TO EAT:_____

_____

PARENT CONCERNS THAT HEAD START NEEDS TO KNOW ABOUT:_____

_____

PARENT CONCERNS THAT MY FAMILY NEEDS HELP WITH:_____

_____

Signature of Parent/Guardian: _____**Date:**_____