FORM N-4

Stockbridge-Munsee Community | Electa Quinney Head Start
CHILD HEALTH RECORD-NUTRITION SCREENING

Child's Full Name **Date of Birth**

Date

Interviewer's Name

Date of Last Physical Exam

Dietary Habits

Please List Child's Favorite Foods

Please List Foods Child Dislikes

☐ - Yes ☐ - No **Does Child Take a Bottle**

☐ - Yes ☐ - No **Does Child Take Vitamin/Mineral Supplements**

☐ - Yes ☐ - No **Do They Contain Iron**

☐ - Yes ☐ - No **Do They Contain Fluoride**

☐ - Yes ☐ - No **Were they Prescribed**

☐ - Yes ☐ - No **Is There Any Food Child Should Not Eat for Medical, Religious, or Personal Reasons**

Please Explain

☐ - Yes ☐ - No **Is Child on a Special Diet**

☐ - Yes ☐ - No **Has There Been a Big Change in Child's Appetite in the Last Month**

☐ - Yes ☐ - No **Does Child Eat Things that are Not Food**

☐ - Yes ☐ - No **Does Child Have Trouble Chewing or Swallowing**

☐ - Yes ☐ - No **Does Child Often Have Diarrhea**

☐ - Yes ☐ - No **Does Child Often Have Constipation**

☐ - Yes ☐ - No **Do You Have Any Concerns About What Your Child Does/Does Not Eat**

About How Often Does Child Eat from the Following Food Groups
Please Indicate the Number of Times/Week

- **Milk, Cheese, Yogurt**
- **Meat, Poultry, Dried Beans/Peas, Peanut Butter**
- **Rice, Grits, Bread, Cereal, Tortillas**
- **Greens, Carrots, Broccoli, Winter Squash, Sweet Potatoes**
- **Oranges, Grapefruit, Tomatoes (Fruit/Juice)**
- **Other Fruits/Vegetables**
- **Oil, Butter, Margarine, Lard**
- **Cakes, Cookies, Sodas, Fruit Drinks, Candy**

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Growth

Date	**Age**
Height (No Shoes) .	**Weight**
Date	**Age**
Height (No Shoes)	**Weight**
Date	**Age**
Height (No Shoes) .	**Weight**

Anemia Screen

Initial Screen

Date	**Hemoglobin**
	Hematocrit

Rescreen

Date	**Hemoglobin**
	Hematocrit

***HGB Less than 11 or HCT Less than 34 Requires Follow-Up**

CRITERIA FOR REFERRAL

Please Review the Items Above. If There are Answers of Concern, or if Growth is Not within the Typical Range, Check the Appropriate Box(es) Below and Consult a Physician

☐ **- Suspect Dietary Problem or Inadequate Food Intake**

☐ **- HGB, Less than 11 gr or HCT Less than 34%**

☐ **- Underweight-Weight Less than Typical (From Growth Chart)**

☐ **- Overweight-Weight More than Typical (From Growth Chart)**

☐ **- Short for Age-Height Less than Typical (From Growth Chart)**

☐ **- Weight for Height Less than Typical (From Growth Chart)**

SIGNATURE

Signature **Date of Screening**