NESD Head Start
NUTRITION ASSESSMENT

Child Name_____
Ctr/HB_____
Interviewer_____
Date_____

Does your child:

	Yes	No
1. Take vitamin or mineral supplements? Comments:	____	____
2. Have a food intolerance or allergy? List intolerances/allergies: _____ _____ Comments:	____	____
3. Require a special diet? Diet:_____ _____ Comments:	____	____
4. Have trouble chewing or swallowing? Comments:	____	____
5. Do you have any concerns about what your child eats? Comments:	____	____

Health/Nutrition Manager reviewed _____ Date_____