Early Head Start - Child Care Partnership
California Department of Education
Nutrition Screener
(Children 13 months of age and older)

Agency Name: TLC Preschool Today's Date: ___ /___ /_____

Child's Name: _____ ☐F ☐M Birth Date: ___ /___ /_____

Are you currently receiving WIC services? ☐Yes ☐No

1. Do you breastfeed your child? ☐Yes ☐No

2. Do you give your child formula? ☐No ☐Yes Brand:_____

4. If your child uses a bottle or sippy cup, where do they take it? ☐N/A
   ☐Bed/Crib ☐Stroller ☐Car Seat ☐Held ☐High chair/Table ☐Other _____

5. If you child drinks from a bottle or sippy cup what do they drink? ☐N/A
   ☐Water ☐Milk ☐Breastmilk ☐Formula ☐Choc./Flavored Milk ☐Water w/ Sugar/Honey
   ☐Soda ☐Lemonade/Punch ☐Tea ☐Pedialyte ☐Juice ☐Milk Substitute (specify) _____

6. What food or beverage does your child eat/drink in an average week?
   ☐Cold/Hot Cereal ☐Vegetables ☐Cheese ☐Rice ☐Beans ☐Tofu ☐Beef/Chicken/Fish
   ☐Hot Dogs/Sausage/Meat Sticks ☐French Fries ☐Bread/Tortilla/Crackers
   ☐Mango/Carrots/Yams ☐Peanut/Nut Butter ☐Dark Leafy Greens (like salad/spinach)
   ☐Cookies/Cake ☐Candy ☐Yogurt ☐Fruits
   ☐Whole Milk ☐Low-fat Milk ☐Water ☐Soda ☐Juice ☐Tea ☐Flavored Milk
   ☐Milk Substitute/rice/soy/oat/almond/other (specify) _____ ☐Other_____

7. My child uses the following (check all that apply): ☐Cup ☐Spoon ☐Fork ☐Fingers
   Does your child have difficulty: ☐Chewing foods ☐Swallowing liquids ☐Feeding self ☐Other_____

8. What are your child's favorite foods?_____
   What foods does your child dislike? _____

9. Does your child eat anything other than food? ☐Paint Chips ☐Dirt / Clay ☐Other _____ ☐N/A

10. My child has: ☐Food Allergies ☐Diarrhea ☐Constipation ☐Anemia ☐Special Diet ☐N/A
    Describe allergy or special diet _____
11. I give my child ☐Vitamins ☐Fluoride ☐Iron Drops ☐Medicine/Type _____ ☐Other _____

12. Do you have questions or concerns about your child's eating or growing?
    _____

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

Signature of Staff:_____ Date: ____ /_____ /_____

Resource Information Provided Date: _____ Staff Initials: _____
Referral to Dietitian / Pediatrician Date: _____ Staff Initials: _____
If a medical disability, must submit a Medical Statement signed by an authorized medical authority.

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