~HSCFDC Documentation/Monitoring System~

Title of Form:	Food Inventory
Related Policy:	Created to ensure compliance with the Head Start Performance Standards as well as identify special nutritional needs and/or feeding concerns with children enrolled in the program.
Program Area:	*1304.23 Child Nutrition*
Procedures	
Filled Out By:	Parents (Teacher explains/ assists)
Timeline:	At Parent Orientation Conference
Specific Directions:	1. Parents are provided form at the orientation conference. 2. Teachers review directions for completing form with parent/guardian. 3. Assistance is offered to complete if necessary. 4. Parents complete the form according to their child's eating habits, by circling foods the child eats or drinks in column one and then by noting the best answer in column two on page one. 5. On page two of the Food Inventory the parents answer the questions completely. 6. The parents sign and date the form and note if consultation is required. 7. Teachers review the form at orientation to ensure all blanks/questions have been completed/answered. 8. Form is sent to Central Office Secretary where it becomes part of the packet provided to the Nutrition Consultant in completing the Nutrition Assessment.
Submitted To:	Central Office and then to Nutrition Consultant
Timeline:	Orientation
Filed In: *Note: For duplicate or triplicate forms, please note where each copy of the form is filed.*	White copy – Central Office Secretary, to be filed with completed Head Start Nutrition Consultant report.

HEAD START FOOD INVENTORY FORM

Revised 05/2013

Center: _____
Child's Name: _____
Date of Birth: _____
☐ Sibling in Head Start
Sibling/s name:_____

Parent Name/s: _____
Phone: _____
Best time to contact: _____
Email: _____
☐ Interpreter needed

Please take time to complete the below questions. This information along with the heights and weights taken at Head Start two times per year will be reviewed by the Head Start Nutrition Consultant. The Nutrition Consultant will contact parents of Head Start children not participating in the WIC program to review the information.

Office Use Only:
BMI %:_____ / Stature %:_____
☐ **Completed (via phone contact)** ☐ **Completed (via written report)**
Notes:

Circle the best answer.

1. Dairy:

My child: Eats/Drinks a variety of dairy **or** Is picky with dairy

My child drinks: Skim Milk 1% milk 2% milk Whole Milk Chocolate Milk Other:_____

My child drinks _____ cups of milk per day.
a) 0-1 cups (0-8oz) per day
b) 2-3 cups (16-24oz) per day
c) 4 or more cups (>32oz) per day

My child enjoys eating other dairy products in addition to milk (yogurt and cheese). Yes No

2. Meat & Beans (includes eggs, peanut butter, fish):

My child: Eats a variety of meats/ beans **or** Is picky with meats/beans

My child eats Meat and/or Beans _____ times per day.
a) 0-1 times per day
b) 2-3 times per day
c) 4-5 times per day
d) 6 times or more per day

3. Grains (includes bread, cereal, crackers, rice, pasta):

My child: Eats a variety of grains **or** Is picky with grains

My child eats Grains _____ times per day.
a) 0-2 times per day
b) 3-5 times per day
c) 6 or more times per day

½ of my child's grain consumption is whole grain? Yes No

4. Fruits:

My child: Eats a variety of fruits **or** Is picky with fruits

My child eats _____ cups of Fruit per day.
a) 0-0.5 cups per day
b) 1-1.5 cups per day
c) 2 cups or more per day

5. Vegetables:

My child: Eats a variety of vegetables **or** Is picky with vegetables

My child eats _____ cups of Vegetables per day.
a) 0-0.5 cups per day
b) 1-2 cups per day
c) 2.5 cups or more per day

6. Extra's (candy, jell-o, cookies, pies, chips, fruit snacks) :

My child eats high sugar/fat containing foods:
a) On occasion (couple times per month)
b) 1 – 3 times per week
c) 4 or more times per week
d) Daily

7. Vitamin C Foods (citrus fruit, berries, broccoli, tomatoes):

My child eats Vitamin C foods_____ times per day.
a) 0 times per day
b) 1 or more times per day

8. Vitamin A Foods (carrots, squash, sweet potato, peaches) :

My child eats Vitamin A foods _____ times per day.
a) 0-2 times a week
b) 3 or more times a week

9. Beverages (soda, diet soda, kool-aid, Gatorade, capri-sun, tea):

My child drinks sugar/caffeine containing beverages:
a) On occasion (couple times per month)
b) 1 time per week
c) 1 time per day
d) 2 or more times per day

10. Juice (100%):

My child drinks _____ cups of 100% juice.
a) On occasion (couple times per month)
b) 0.5 - 1 cup per day.
c) 1.5 cups or more per day.

11. Water: (Circle Which Type)
My child: Likes to drink water **or** Is picky with water

My child drinks:

a) City/Tap Water
b) Bottled Water
c) Flavored Water
d) Well Water
   a. Well Water has: Been Tested or Not Been Tested

12. If your child drinks non-fluoride water (such as city with no fluoride, bottled, flavored or well water), does he/she take a fluoride supplement? Yes No

13. Physical Activity
My child gets _____ of physical activity per day.

a) Less than 30 minutes per day (Sedentary)
b) 30-60 minutes per day (Moderately Active)
c) 60 or more minutes per day (Active)

14. TV/Video/Video Games/Computer:
My child spends ___ hours watching TV/Video/Video games/Computer.

a) Our family does not have TV/Video/Video games/Computer
b) ½ -2 hours per day
c) More than 2.5 hours per day

15. Is your child allergic to any foods? Yes No
If yes, please list: _____

16. Is your child on a special diet? Yes No
If yes, explain:_____

17. Fast Food/Restaurant:
My child eats at fast food/restaurants_____ times per week?

a) We do not eat out on a regular basis
b) 1 time per week
b) 2 or more times per week

18. My child drinks from a:

a) Bottle
b) Sippy Cup
c) Regular Cup

18. My child takes beverages to bed to drink. Yes No
If yes, please circle:
Juice Milk Water Other:_____

19. My child request/eats non-food items. Yes No
If yes, please circle
Dirt Clay Paint chips Ice
Refrigerator Frost Laundry/Corn Starch Pencils

20. My child appears:

a) Just Right
b) Underweight
c) Overweight
d) Short

21. My child experiences diarrhea or constipation often? Yes No
If yes, please circle Diarrhea Constipation
Do you do any treatment for the diarrhea or constipation?
_____

22. Does your child help with mealtime (wash foods, mixing, setting the table, serving themselves)? Yes No

23. I rate my child's appetite as:

a) Poor
b) Fair
c) Good

24. What does your child usually eat for breakfast?
List: _____

25. What does your child usually have for a snack?
List: _____

26. Are you satisfied with what your child eats? Yes No
If no, please explain: _____

27. What foods does your child dislike?
List: _____

28. Does your child take a vitamin or supplement? Yes No
If yes, list: _____

29. Do you have nutrition concerns with your child? Yes No
( ) I wish to meet or talk with the Head Start Nutrition Consultant to assist me with the following specific nutrition problems/concerns:
_____

30. Resources Teacher: Please review and initial Resources section and indicate referrals made.	**Yes**	**No**	**Teacher Initial**	**Resource Information Given**	**Referral Card Completed**	**Resource Info. Offered- Parent Refused**
A. Do you ever run out of food to the feed the child or family?						
B. Are you receiving WIC checks/drafts?						
C. Are you receiving Food Stamps/Food Share/Quest Card?						
D. Does your child live in a home with running water?						
E. Does this child live in a home with a working stove?						
F. Does this child live in a home with a working refrigerator?						

Signature of parent/guardian:_____ Date: ____/_____/____

Teacher Signature: _____ Date: ____/_____/____