COLLEGE OF SOUTHERN IDAHO HEAD START/EARLY HEAD START
Please remember to have your provider fill in the Early Head Start Well Child
998 Washington St. N.
PO Box 1238
Twin Falls, Idaho 83303-1238

Anticipatory Guidance for the 30 Month Well Child Physician Visit

Follow-up visit from 24 month Well Child Exam concern.

Date_____

My child is _____months old.

He/she weights _____and is _____long.

At this visit you can expect:

o _____
o _____
o _____
o _____
o _____
o _____

You might want to discuss with your provider:

o _____
o _____
o _____
o _____
o _____
o _____

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208-736-0741

9-36 Month Nutritional Screening and Anticipatory Guidance

To be completed within 45 days of enrollment and following each age interval of: ***9, 12, 15, 18, 24, 30, and 36 months of age***

Office Use Only:	Enrollment Date:	FE Name:

Child's Name: _____

Date of Birth: _____ Parent/Guardian Names: _____

How many meals and snacks are offered to your child daily: _____ Meals _____ Snacks

Does your child:		**How often?**	**Comments**
Drink from a bottle	__ Yes __No	___times/day	_____
Drink from a cup	__ Yes __No	___times/day	_____
Take a bottle to bed	__ Yes __No	___times/day	_____

Does your child drink any of the following?

Breast milk	__Yes __ No	___times/day	_____
Formula	__Yes __ No	___times/day	type_____
Cows milk (pasteurized)	__Yes __ No	___times/day	1%,2%,whole_____
Evaporated milk	__Yes __ No	___times/day	_____
Soy or Rice Milk	__Yes __ No	___times/day	_____
Goats milk	__Yes __ No	___times/day	_____
Water	__Yes __ No	___times/day	_____
Juice	__Yes __ No	___times/day	_____
Tea	__Yes __ No	___times/day	_____
Kool-Aid/Soda	__Yes __ No	___times/day	_____
Cows milk (raw)	__Yes __ No	___times/day	_____

Does your child:		How Often?	Comments
Take vitamin or mineral supplements?	__ Yes __ No	_____times/day	_____
Take herbal supplements?	__Yes __ No	_____times/day	_____
Take iron supplements?	__Yes __ No	_____times/day	_____
Eat non-food items?	__Yes __ No	_____times/day	_____

Are there any foods your child may not eat for personal, cultural, ethnic, religious, or health reasons?
__Yes __No *If yes, which ones*? _____
If yes, Please fill out a Food Preference form

Does your child have any special food or nutritional needs? __Yes __No
If yes, please explain: _____
If yes, Please fill out a Medical Food Substitution form

Child's Favorite Foods: _____
Child's Least Favorite Foods: _____
Are there any specific foods that you would like to see at Early Head Start Family Gatherings?
_____

Is your child on WIC?	__Yes __ No
Do your food dollars meet your family need?	__Yes __ No
Does your child live in a home that has running water?	__Yes __ No
Does your child live in a home that has a working stove and refrigerator?	__Yes __ No

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DAILY NUTRITIONAL INTAKE

Please write down everything that your child ate yesterday.
Was this a typical day? __Yes __ No

Time	Food/Drink Consumed	Amount Consumed (Cups, ounces, spoon-fuls, etc.)	Notes

Do you have any concerns about your child's eating patterns? __ Yes __ No
If yes, please explain? _____
_____
_____

If yes, Please send a copy of this form to the child's Primary Medical Provider

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Staff Signature **Date**