

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.

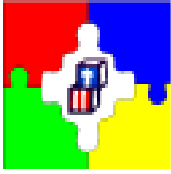
He/she weights _____ and is _____ long.

At this visit you can expect:

- _____
- _____
- _____
- _____
- _____
- _____

You might want to discuss with your provider:

- _____
- _____
- _____
- _____
- _____
- _____



COLLEGE OF SOUTHERN IDAHO HEAD START/EARLY HEAD START

998 Washington St. N.
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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

Table with 3 columns: Does your child:, How often?, Comments. Rows include Drink from a bottle, Drink from a cup, Take a bottle to bed.

Does your child drink any of the following?

Table with 3 columns: Does your child:, How often?, Comments. Rows include Breast milk, Formula, Cows milk (pasteurized), Evaporated milk, Soy or Rice Milk, Goats milk, Water, Juice, Tea, Kool-Aid/Soda, Cows milk (raw).

Table with 3 columns: Does your child:, How Often?, Comments. Rows include Take vitamin or mineral supplements?, Take herbal supplements?, Take iron supplements?, Eat non-food items?.

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