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:

ο _______________________________________________________________________________________

ο _______________________________________________________________________________________

ο _______________________________________________________________________________________

ο _______________________________________________________________________________________

ο _______________________________________________________________________________________

ο _______________________________________________________________________________________
# 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*

<table>
<thead>
<tr>
<th>Office Use Only</th>
<th>Enrollment Date</th>
<th>FE Name</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th>How often?</th>
<th>Comments</th>
</tr>
</thead>
</table>

#### 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?

<table>
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<tr>
<th>How often?</th>
<th>Comments</th>
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</thead>
</table>

#### Breast milk

- Yes
- No
- times/day

#### Formula

- Yes
- No
- times/day

#### Cows milk (pasteurized)

- Yes
- No
- times/day

#### 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:

<table>
<thead>
<tr>
<th>How Often?</th>
<th>Comments</th>
</tr>
</thead>
</table>

#### 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, 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
Please write down everything that your child ate yesterday.

Was this a typical day?    __Yes    __No

<table>
<thead>
<tr>
<th>Time</th>
<th>Food/Drink Consumed</th>
<th>Amount Consumed (Cups, ounces, spoonfuls, etc.)</th>
<th>Notes</th>
</tr>
</thead>
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</table>

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