INFANT NUTRITION/HEALTH QUESTIONNAIRE (0-12 months)

Center-Based: Complete a NEW FORM twice a year and review/update each form 3 months later. (Total of 4 meetings a year with parent)
Home-Based: Complete the questionnaire only when a child does not have a current Well-Baby Exam on file. Review/updates not required.

Child's Name: _____ **Date of Birth:** _____

DIETARY HABITS

1. Which of the following does your child drink?
   □ breast milk □ formula: _____ □ breast & bottle □ cow's milk □ soy milk □ almond milk
   □ other _____ (a) How much milk does your child drink each day and when? _____

2. Does your child have any food allergies or intolerances? □ no □ yes
   *If yes, submit a completed Request for Special Meals and/or Accommodations form to the Central Kitchen

3. Which foods do you give your child?

Ages 0-6 months: (see question 1)

Ages 6-8 months: □ rice cereal □ Iron-fortified cereal □ pureed fruits/vegetables □ pureed meats or beans

Ages 8-10 months: □ Iron-fortified cereal □ mashed fruits/vegetables □ teething crackers □ bread (small pieces)
□ eggs (well-cooked) □ pureed meats/beans □ dairy: soft cheese/yogurt □ none □ other:_____

Ages 10-12 months: □ Iron-fortified cereal □ cut up fruits/vegetables □ teething crackers □ bread (small pieces)
□ eggs (well-cooked) □ pureed meats/beans □ dairy: soft cheese/yogurt □ none □ other:_____

4. What is the consistency? □ puree □ strained □ diced/chopped □ finger food □ whole □ other: _____

5. When does your child eat and how much? (include times and amount served, like: 'a handful' or 'half of a small plate')
Does your child have any special feeding or meal time routines?

INDIVIDUAL DIAPERING PLAN

6. How often do you change your child's diaper? When does your child usually need a diaper change?

7. What concerns/instructions do you have about your child's daily diapering/toileting needs?

SLEEPING PATTERNS

8. When does your child usually sleep, and how long are they typically asleep for?

9. What helps your child to fall asleep?

SPECIAL NEEDS PLAN

10. Is your child under the care of a physician right now? □ no □ yes condition: _____
    *If yes, may require an IHP or Special Diet

11. Does your child have a diagnosed disability? □ no □ yes disability: _____

Additional comments/updates:

Initial Interview

Parent's Name: _____ **Parent's Signature:** _____ **Date:** ____/____/____

Staff Name: _____ **Staff Signature:** _____ **Date:** ____/____/____

Review/Update 3 months later (Center-Based Only) □ no updates

Parent's Name: _____ **Parent's Signature:** _____ **Date:** ____/____/____

Staff Name: _____ **Staff Signature:** _____ **Date:** ____/____/____