

*Appendix A*

# CHILDREN WITH SPECIAL HEALTH CARE NEEDS

## NUTRITION SCREENING

Dear Parent or Guardian:

**Nutrition services are offered to all children in Spokane County attending Spokane Guilds' School by the Children with Special Health Care Needs Program. I will contact you soon if you have a nutrition concern and set up a convenient time to meet with you.**

Please complete this Nutrition Screening form for your child. Today's date \_\_\_\_\_

Child \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_ Sex: M F (circle)  
 Premature? yes \_\_\_ no \_\_\_ If yes, number of weeks \_\_\_\_\_ Birth weight \_\_\_\_\_

Your Name \_\_\_\_\_ Relationship to child \_\_\_\_\_  
 Phone number \_\_\_\_\_ Zip Code \_\_\_\_\_

Diagnosis \_\_\_\_\_

CURRENT NUTRITION CONCERNS ABOUT THIS CHILD: (Please check all that apply)

	YES	NO	UNSURE
Seems underweight.....	_____	_____	_____
Seems overweight.....	_____	_____	_____
Food intolerances/allergies, to what? _____	_____	_____	_____
Frequent constipation.....	_____	_____	_____
Frequent diarrhea .....	_____	_____	_____
Frequent throwing up/vomiting .....	_____	_____	_____
On a tube feeding.....	_____	_____	_____
Takes a long time to eat .....	_____	_____	_____
Has trouble eating textured or chunky foods.....	_____	_____	_____
Has difficulty taking liquids: formula/water/juice.....	_____	_____	_____
Often chokes and gags on foods.....	_____	_____	_____
Is a picky eater .....	_____	_____	_____
On a special diet, specify _____	_____	_____	_____

My child takes the following medicines: \_\_\_\_\_

Vitamin/mineral supplements taken: \_\_\_\_\_

What kind of milk or formula does your child drink? \_\_\_\_\_ How much per day? \_\_\_\_\_

Uses bottle \_\_\_\_\_ cup \_\_\_\_\_ both \_\_\_\_\_ other \_\_\_\_\_

Please list any other nutrition concerns you have:

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<u>Ethnicity: (circle one)</u>	<u>Community Programs currently enrolled in: (circle all that apply)</u>	
Black/African American	CSHCN	WIC
Hispanic	Food Stamps	Medicaid
Caucasian	SSI	Private Insurance
Native American	CHAMPUS	Foster Care
Asian/Pacific Islander	DDD	
Other		

Thank you for providing this important information about your child. Please return this form to

\_\_\_\_\_.

For office use only:			
Evaluation by therapists: _____	Completed by _____		
Describe child's feeding skill level: _____			
Observations of parent-child interaction _____			
Additional comments: _____			
Nutritionist: _____	Completed by _____		
Weight _____	Height _____	Head Circumference _____	
Weight/age ___%	Height/age _____%	Weight/Height _____%	OFC _____%
COMMENTS: _____			
_____			
_____			
_____			
_____			
Action taken: _____			
_____			
_____			
_____			
_____			