SOUTHERN OREGON HEAD START	1001 Beall Lane, PO Box 3697, Central Point, OR 97502 541-734-5150, fax 541-245-2279	**School Year:** 19-20 **Date Completed:** 06/28/2019 **Completed By:** Initial

HEALTH HISTORY QUESTIONNAIRE

Child's Name: Cookie Monster		**DOB:** 01/01/2019
Guardian Name: Mama Cookie Monster	**Center:** EHS WM	**FA:** My Name

INSURANCE AND PRIMARY CARE

Is your family eligible for Medicaid (OHP)? (doesn't mean they are necessarily enrolled)	(●) Entire family eligible ( ) Entire family ineligible ( ) Guardian(s) ineligible ( ) Other Children ineligible
What is your current health insurance enrollment status of your family? (OHP or others)	(●) Entire family insured ( ) Entire family uninsured ( ) Guardian(s) uninsured ( ) Other Children uninsured
Does your Head Start Child have Health Insurance?	(●) Yes ( ) No
If yes, do you know your renewal date? (●) Yes ( ) No	Renewal month: October 2019, Blank if unknown
Insurance provider	( ) Private (●) Medicaid (OHP) ( ) Other: fill out if other

Insurance Plan: (CCO: e.g. AllCare, JCC, Primary Health; or if Private- Blue Cross, etc)	listed on insurance card	**Insurance #**	listed on their insurance card
Dental Plan: (DCO: e.g. Advantage, Capitol; or if private i.e. Delta Dental, QVI, etc)	listed on insurance card	**Dental Plan #**	- Usually not listed

Medical Home (clinic or office)	SO Pediatrics	**Provider name**	Dr. Doctor	**Last appt**	6/1/2019 Blank if unknown
Dental Home (clinic or office)	Advantage, Medford	**Dentist name**	Dr. Dentist	**Last appt**	6/1/2019 Blank if unknown

Are you satisfied with your current medical and dental care?	( ) Yes (●) No

If no, please explain: Ask family if they need assistance switching providers, and what problems they are having. Use the Provider list to help them find a new one. They will have to call to get it switched.

If no insurance or medical/dental home, would you like help accessing care?	(●) Yes ( ) No

Details on needs, and any resources provided: If they need assistance, a brief description of what they need- renewal, application, change of address, change of income, don't know who they're assigned to, etc.

PERSONAL HEALTH HISTORY

Is child UTD on vaccinations? (Either way, review CIS form & have parent sign) ◯ Yes ◯ No ◯ Exempt

Ever had vaccine preventable illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox

Notes on Immunizations: If they have had one of the above conditions, please list info on approximately when. Also note here if out of state, doing exemption, etc.

Has the child been diagnosed with any of the following conditions?
(note the date diagnosed, details of condition, and obtain ROI-S if accommodations are needed)

☐ Food Allergy* Make notes here for all entries	☐ High Lead Levels
☐ Other Allergy It is very helpful to have the date	☐ Anemia (low iron)
☐ Asthma* diagnosed for conditions as well.	☐ Overweight
☐ Bleeding condition	☐ Underweight
☐ Diabetes	☐ Hearing Problems
☐ Cancer	☐ Vision Problems
☐ Heart Conditions	☐ Broken Bones
☐ Seizures*	☐ Joint problems
☐ Sickle Cell Disease	
☐ Dental or oral needs	
☐ Other:	

* fill out the associated medical condition questionnaire

Is the child currently receiving medical treatment for a diagnosed condition?

◉ Yes ◯ No If Yes, explain: Give us info here so when you get the ROI-S we have an idea what it is for.

If Yes, are you satisfied with the care for their condition? ◯ Yes ◉ No

If No: Please explain: If not, again talk about supports for the family, advocating for their needs, and how to switch providers.

Is your child on any Medications? ◉ Yes ◯ No
(Note: if we have the info on another form – i.e. Asthma, Seizures, Food Sub- just list the meds below)

If Yes: List medications: List meds, be sure and get ROI-S if needed at school

^Do meds need to be at school? ◯ Yes ◯ No; Is it Rescue Medication? ◯ Yes ◯ No

^ if it is emergency or rescue medication it must be at school before the child can attend.

Is there anything else we need to know about the medication(s)? (e.g. side effects)
Side effects are really important to know, also triggers or what causes need of medication.

Are there any accommodations needed for your child in the classroom? ◉ Yes ◯ No

If yes: Please explain: Any other things that may affect child in classroom life, list here.

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Revised: 08/13/2018 SF

	1001 Beall Lane, PO Box 3697, Central Point, OR 97502 541-734-5150, fax 541-245-2279	School Year: 19-20 Date completed: 06/28/2019 Completed by: Initial

NUTRITION ASSESSMENT

Child's Name: Cookie Monster		DOB: 01/01/2019
Guardian Name: Mama Monster	Center: EHS__	FA: My Name

1.	**Are there foods your child especially likes?**	
	If yes, list top 3: This is to start converstaion with family and gather general info	
2.	**Are there foods your child especially dislikes?**	
	If yes, list top 3: Again, just to continue conversation and get an idea of child's eating habits	
3.	**Are there foods your child should not eat for medical reasons?**	◉ Yes ○ No
	If yes, explain: (Fill out Food Sub form) FILL OUT FOOD SUBSTIUTION FORM IF YES. Also make brief note here as to what foods. If new diagnosis in last 6 months, encourage a referral to our RD.	
4.	**Are there foods your child does not eat for cultural or religious reasons?**	◉ Yes ○ No
	If yes, explain: (Fill out Food Sub form) FILL OUT FOOD SUBSTIUTION FORM IF YES. Also make brief note here as to what foods. Ensure they know that we can't guarantee we can sub for preferences	
5.	**Has there been any change in your child's appetite in the past month?**	○ Yes ○ No
	If yes, describe: This is an indicator of concerns. If big changes should encourage to talk to doctor, or we can refer to nutritionist (see #23 on page 2 to indicate a referral)	
6.	**Does your child have trouble chewing or swallowing?**	○ Yes ○ No
	If yes, describe: If yes, encourage to see their doctor, if they have seen their doctor for it, get an ROI-S, and ask if we need to accommodate in any way.	
7.	**Does your child eat or chew on things that are not food?** (other than normal teething activity)	○ Yes ○ No
	If yes, describe: If yes, refer to their primary care doctor for evaluation. If PICA has already been diagnosed, get ROI-S and do ROI-RD for referral.	
8.	**Does your child often have diarrhea?**	○ Yes ○ No
	If yes, how often: if persistent, see doctor	
9.	**Does your child often have constipation?**	○ Yes ○ No
	If yes, how often: if persistent, see doctor	
10.	**Does your child often have nausea or vomiting?**	○ Yes ○ No
	If yes, how often: if persistent, see doctor	
11.	**Do you have any concerns about what your child eats or eating habits?**	○ Yes ○ No
	If yes, explain: Talk about any aversions, such as to textures or colors as well. We are working on getting handouts for these.	
12.	**What do your meal times look like?** (times of day, who all there, same foods for all, snacks regularly, etc.)	Getting an idea of their routines. Gathering info on how you could support them. Important things to bring up- limiting distractions such as TV or eating in area with distractions, may want to use handout "Watch Less TV"

For the following questions, please indicate how many servings a day your child (or prenatal mom) eats of each food group. (use visuals for serving sizes)

13. Protein, such as MEAT, POULTRY, FISH, EGGS, BEANS, PEANUT BUTTER, NUTS

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Protein Foods" handout

14. Grains, such as RICE, GRITS, PASTA, CEREAL, TORTILLAS

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Whole Grains" handout

15. Vegetables, such as SALAD, CARROTS, BROCCOLI, SQUASH, PEAS, BELL PEPPERS

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Fruits and Vegetables" handout

16. Fruit, such as ORANGES, APPLES, BANANAS, GRAPES, STRAWBERRIES, MANGOS

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Fruits and Vegetables" handout

17. Dairy, such as MILK, CHEESE, YOGURT

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"I'm Thirsty" handout

What fat % milk do they drink? ○ Skim ○ 1% ○ 2% ○ Whole

"Switch to 1% Milk" handout

18. WATER, how many cups (8oz cups) of water does your child drink a day?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Drink Water"

19. Sweet Drinks, such as SODA, JUICE, KOOL-AID, SPORTS DRINKS

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Sweet Drinks" handout

20. Caffeinated Drinks, such as SODA, ENERGY DRINKS, ICED TEA, COFFEE

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"I'm Thirsty" handout

21. Fats, such as MAYO, BUTTER, LARD, MARGERINE, OIL, CHIPS, FRIED FOODS

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Eat some foods less often" handout

22. Sweets, such as CAKES, COOKIES, CANDY

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"The Sweet Tooth" handout

23. Do you have any nutrition concerns that you would like to speak to a Registered Dietician about? ○ Yes ○ No; **If yes**, do you currently receive WIC? ○ Yes ○ No

24. Any additional comments about your child's daily nutrition or eating habits?

Fill out ROI-Dietician if they would like to talk to one. One concern we see is Stuffing food- ask about food security/changes in home, and ask if need resources. Can do ROI-Dietician for support

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Last Revision Date: 08/13/2018 SF

	1001 Beall Lane, PO Box 3697, Central Point, OR 97502 541-734-5150, fax 541-245-2279	School Year: Date completed: Completed by:

NUTRITION ASSESSMENT

Child's Name: BROCHURE HANDOUTS as of 6/28/19		DOB:
Guardian Name:	Center:	FA:

1.	**Are there foods your child especially likes?** If yes, list top 3:	
2.	**Are there foods your child especially dislikes?** If yes, list top 3: Ten Tips for Feeding Picky Eaters - Nutrition Matters	
3.	**Are there foods your child should not eat for medical reasons?** If yes, explain: (Fill out Food Sub form)	○ Yes ○ No
4.	**Are there foods your child does not eat for cultural or religious reasons?** If yes, explain: (Fill out Food Sub form)	○ Yes ○ No
5.	**Has there been any change in your child's appetite in the past month?** If yes, describe:	○ Yes ○ No
6.	**Does your child have trouble chewing or swallowing?** If yes, describe: Prevent Choking - Nutrition Matters	○ Yes ○ No
7.	**Does your child eat or chew on things that are not food?** (other than normal teething activity) If yes, describe:	○ Yes ○ No
8.	**Does your child often have diarrhea?** If yes, how often: Diarrhea - Noodle Soup	○ Yes ○ No
9.	**Does your child often have constipation?** If yes, how often: Constipation & Your Child - Noodle Soup	○ Yes ○ No
10.	**Does your child often have nausea or vomiting?** If yes, how often:	○ Yes ○ No
11.	**Do you have any concerns about what your child eats or eating habits?** If yes, explain: Ten Tips for Feeding Picky Eaters - Nutrition Matters	○ Yes ○ No
12.	**What do your meal times look like?** (times of day, who all there, same foods for all, snacks regularly, etc.)	Family Meals and My Plate, Healthy Eating Styles - both Nutrition Matters Also Watch Less TV- Nutrition Matters

For the following questions, please indicate how many servings a day your child (or prenatal mom) eats of each food group. (use visuals for serving sizes)

13. Protein, such as MEAT, POULTRY, FISH, EGGS, BEANS, PEANUT BUTTER, NUTS

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Protein Foods" handout

14. Grains, such as RICE, GRITS, PASTA, CEREAL, TORTILLAS

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Whole Grains" handout

15. Vegetables, such as SALAD, CARROTS, BROCCOLI, SQUASH, PEAS, BELL PEPPERS

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Fruits and Vegetables" handout

16. Fruit, such as ORANGES, APPLES, BANANAS, GRAPES, STRAWBERRIES, MANGOS

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Fruits and Vegetables" handout

17. Dairy, such as MILK, CHEESE, YOGURT

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"I'm Thirsty" handout

What fat % milk do they drink? ○ Skim ○ 1% ○ 2% ○ Whole

"Switch to 1% Milk" handout

18. WATER, how many cups (8oz cups) of water does your child drink a day?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Drink Water"

19. Sweet Drinks, such as SODA, JUICE, KOOL-AID, SPORTS DRINKS

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Sweet Drinks" handout

20. Caffeinated Drinks, such as SODA, ENERGY DRINKS, ICED TEA, COFFEE

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"I'm Thirsty" handout

21. Fats, such as MAYO, BUTTER, LARD, MARGERINE, OIL, CHIPS, FRIED FOODS

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"Eat some foods less often" handout

22. Sweets, such as CAKES, COOKIES, CANDY

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6+

"The Sweet Tooth" handout

23. Do you have any nutrition concerns that you would like to speak to a Registered Dietician about? ○ Yes ○ No; **If yes**, do you currently receive WIC? ○ Yes ○ No

24. Any additional comments about your child's daily nutrition or eating habits?

Also have Play Inside (good for winter months) and Play Outside for if they are concerned about weight. Concerns of overweight, give "How to Talk about Weight" brochure.

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Southern Oregon Child and Family Council Inc.
1001 Beall Lane *P.O. Box 3697* Central Point, OR 97502 * (541) 734-5150 - Fax (541) 734-5229

AUTHORIZATION FOR RELEASE & EXCHANGE OF INFORMATION with a Registered Dietitian
AUTORIZACIÓN PARA LA DIVULGACIÓN e intercambio de información con un Dietista Registrado

Child's Name:______________________ Date of Birth:______________________
Nombre del Niño *Fecha de nacimiento*

Parent/Guardian Name:______________________________________
Nombre del Pariente/Guardián

___ I give my permission for Head Start/Early Head Start to share, receive and review information with the listed Registered Dietitian.
Doy mi permiso para que Head Start/Early Head Start comparta, reciba y revise información con el dietista registrado.

RD Name: Megan Robinson, RD.
Nombre del dietista

Parent or Guardian's preferred method of contact, check all that are preferred:
El método de contacto preferido del pariente o el guardián, cheque todos los que prefiere:

___Phone/*Teléfono*:______________________Call/*Llamada*_____ Text/*Texto*___

___Email/*Correo electrónico*:______________________________________

Best time to be contacted by the RD /*¿Cuál es la mejor hora para que la dietista la (lo) contacte?:*

____

Reason for requesting RD assistance /*Razón por la que requiere asesoría de la dietista:*

____

I hereby authorize the Registered Dietitian to release and/or exchange information with Southern Oregon Head Start for the purpose of establishing the health status of my child or myself, listed as participant.

Por la presente autorizo un dietista registrado para dar y/o intercambiar información con Head Start con el fin de establecer el estado de salud de mi hijo o de mi mismo, quienes aparecemos como participantes.

I have reviewed this Authorization and understand that: The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under Federal Law. I have the right to revoke this Authorization, provided I do so in writing and except to the extent that we have already used or disclosed the information requested on this Authorization. Refusal to sign this Authorization will not adversely affect eligibility for enrollment in this program. This request expires one year from signature date.

He revisado esta autorización y entiendo que la información usada, distribuida o expuesta con esta autorización podría ser rehusada con este recibo y dejar de estar protegida por la ley federal. Tengo el derecho de anular esta autorización en cualquier momento, si asi lo deseo es necesario hacerlo por escrito, sabiendo que la información que ya se uso e intercambio relacionada con esta autorización esta excluida. La negación de firmar este documento no afectara la elegibilidad para inscribirse a este programa. Este recibo se anulara un año después del día que se firmo.

______________________________________ ______________________
Signature of Parent/Guardian/ *Firma del Pariente/* Guardián **Date/Fecha**

1001 Beall Lane, PO Box 3697,
Central Point, OR 97502
541-734-5150, fax 541-245-2279

School Year: 19-20
Date completed: 06/28/2019
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FOOD SUBSTITUTION QUESTIONNAIRE

Child's Name: Cookie Monster	DOB: 01/01/2019
Guardian Name: Mama Monster	Center: EHS__ FA: My Name

FOOD ALLERGIES/INTOLERANCES/SENSITIVITIES/PREFERENCES

(e.g. strawberries, peanuts, dairy, vegetarian, etc.)

1. **List Food(s):** if there are multiple foods that cause different effects or meds, fill out 2 forms
   Is this a(n): (•) Allergy ( ) Intolerance ( ) Sensitivity ( ) Preference **(skip to Question 11.)**
2. **What triggers the reaction?** ☒ Eating it ☒ Touching it ☒ Smelling it/indirect exposure
3. What is the reaction? describe the reaction (hives, redness around mouth, breathing proble
4. What do you do to treat the reaction? what does the parent do at home?
5. **Do you omit foods from your child's diet at home?** ( ) Yes ( ) No
   If so, what do you substitute with? sometimes they don't omit at home, have to either totally omit at school, or totally allow. List foods given instead at home, listing brands if known
6. **Can the child have the food if it is an ingredient in a food item?** (•) Yes ( ) No
   Explain/give examples: This is important for the cooks to check labels. Example: no Dairy, can it be an ingredient- yes. So can they have muffins with butter and milk as an ingredient
7. **Is your Doctor or medical provider aware of the reaction?** (•) Yes (ROI-S if needed) ( ) No
8. **Would the caregiver like a food substitution at school?** (•) Yes ( ) No
   If yes: ( ) Approved Beverage e.g. Soy milk or Lactaid ( ) Food, within component e.g. specific fruit or nut, etc. (•) Full food component e.g. all dairy, all grains, etc. (ROI-S required)
9. Any additional notes about the allergy?
   Complete the beverage substitution form if only for fluid milk. For full component, must have ROI-S, so they must have seen their Dr. about it. If not, let them know they need to.
10. **Is medication needed?** (•) Yes ( ) No **If yes, is it needed at school?** (•) Yes (ROI-S) ( ) No
    Medication: Name of med **Prescribed by:** Dr. that prescribed
    Medication instructions: Info on how the parent gives medication. If it is OTC, not prescribed, let the parent know they need to discuss with doctor, as we will have to have Dr. info
    Note: if the medication is for emergency response, it must be at school before the child can attend.

Food Preferences: We cannot guarantee the child won't eat the listed items, and some sites can't accommodate preferences.

11. **Are there foods your child does not eat for cultural or religious reasons?** ( ) Yes ( ) No
    If yes, check all child CANNOT eat: (we cannot accommodate vegan diets) ☒ Pork ☒ Beef ☒ Chicken ☒ Turkey ☒ Fish ☒ Shellfish ☒ Eggs ☐ Other:
    Can any of these foods be eaten if they are an ingredient in a dish? ( ) Yes ( ) No
    Explain: Make sure and be as specific as possible. Yes or no for being an ingredient, make notes here. Think of things like broths when thinking about as ingredients.

Attach additional information as needed if there are multiple allergies.

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