

DATE: \_\_\_\_\_

## HEAD START/EARLY HEAD START NUTRITIONAL SERVICES ASSESSMENT AND FOLLOW UP LOG

FY 2006-2007

SITE NAME: \_\_\_\_\_

NUTRITION REPRESENTATIVE: \_\_\_\_\_

HEAD START  EARLY HEAD START

CHILD'S NAME	DOB	CR #	Ht.	Wt.	Wt/Ht		Head Circum.	H/H	H/H LOW	EPSDT Date	A	S/D	Ref.	F/U DATE		COMMENTS	
					<5%	>90%								1st	Continued		
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
<b>TOTAL OF NUTRITIONAL SERVICES</b>					<b>0</b>	<b>0</b>			<b>0</b>		<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>		

Referral	R	Allergies	A	Hemoglobin	H/H	QA Nurse	QAN
Follow Up	F/U	Date of Birth	DOB	Special Diet	S/D	Social Services	SS
Classroom	CR #	Height	Ht.	Disability Serv.	DS	Center Director	CD
		Weight	Wt.	Nutrition	N		