Health, Developmental, Nutritional Assessment (HDNA) HD new

Child's Name	Gender	DOB	Age	Date
	[ ] M [ ] F			

Parent/Guardian Name	Relationship to Child	Language
	__Parent __Foster __Other _____	

Interviewer	Center & Class	Teacher/Primary Caregiver	AM/PM/HB/FD/FCC (circle one)

DEVELOPMENTAL HISTORY	Circle	STAFF INTERVENTION (If yes, refer or counsel as indicated)
PREGNANCY/DEVELOPMENTAL HISTORY		
1. Mother's age at child's birth? [ ] Under 18 [ ] 18-30 [ ] over 30		Child's birth weight _____lbs. _____oz.
2. Was child born more than 3 weeks early or late?	Y N	How Early:_____How Late:_____
3. Was baby in the NICU?	Y N	How Long?
4. Were there any complications with the pregnancy or birth?	Y N	Describe:
5. Did mother smoke, drink alcohol, or use drugs during pregnancy?	Y N not asked	Describe:
6. When did your child sit without help? [ ]3-6 mo. [ ] 6-12 mo. [ ] over 12 mo.		
7. When did your child crawl? [ ] Never [ ] 3-6 mo. [ ] 6-12 mo.		
8. When did your child walk without help? [ ] 9-12 mo. [ ] 12-15 mo. [ ] over 15 mo.		
9. When did your child talk? [ ] 1-2 years [ ] 2-3 years [ ] over 3 years		
CURRENT DEVELOPMENTAL HISTORY		
1. Describe your child's sleep: Goes to bed at _____Gets up at_____Takes a nap: Y N Has trouble sleeping: Y N		
2. Does your child wear diapers/pull ups?	Y N	__Daytime __Nighttime Head Start provides diapers.
3. If your child is toilet trained, does he/she have accidents?	Y N	
HEALTH HISTORY		
1a. Child's last physical exam? _____ 1b. Who is the child's doctor? _____		Phone # _____ [ ] if none, provide MD referral list
2. Has your child ever had a blood lead test completed? If yes, Where?	Y N	Obtain the date and result.
3. Has your child ever had a serious illness, accident, or hospitilization?	Y N	Describe:
4. Does your child have an ongoing health condition, such as: [ ] Asthma [ ] Diabetes [ ] Downs Syndrome [ ] Kidney Disease [ ] Heart Condition/Murmur [ ] Seizures [ ] Other		Describe:
5. Is your child currently taking any medication?	Y N	What? When?
6. Does your child need to take any medication while at center?	Y N	If yes, follow Medication Administration policy in the Child Health and Safety section of the Health Manual.
7. Does your child take: [ ]Vitamins [ ]Vitamins with Iron [ ] Fluoride		Follow MD guidelines for fluoride and iron.
8. Does anyone in your household smoke?	Y N	If yes, give Second Hand Smoke pamphlet
9. Does your child receive any of the following services: [ ] speech therapy [ ] Parent Infant Programs [ ] Far Northern Regional Center services [ ] physical therapy [ ] occupational therapy [ ] have an IEP or IFSP		
VISION HISTORY		
1. Does your child have any of the following: [ ] crossed eyes [ ] holds objects close [ ]squinting		
2. Has your child ever seen an eye doctor? If Yes, When?_____Who?_____ Glasses Prescribed? Y N	Y N	If Yes, have parent sign "Authorization to Release Information" and request most recent eye exam and scan to health.
HEARING HISTORY		
1. Does your child have any of the following: [ ] frequent ear infections [ ] trouble hearing		
2. Has your child ever seen an audiologist for hearing? If Yes, When?_____Who?_____ Wears hearing aides? Y N Has Tubes? Y N	Y N	If Yes, have parent sign "Authorization to Release Information" and request most recent report and scan to health.
3. **Ask only if child is 0-6 months old at time of enrollment**. Newborn Hearing Screening. *Done at hospital at birth.*	Y N	____Passed ____Needs Follow-Up

SHASTA HEAD START HEALTH, DEVELOPMENTAL AND NUTRITIONAL ASSESSMENT (HDNA)

Child's Name	Center & Class	Gender	DOB	Age	Date
		[ ] M [ ] F			

HEALTH HISTORY	Circle	STAFF INTERVENTION (If yes, refer or counsel as indicated)

DENTAL HISTORY

1a. Child's last dental exam? _____	Phone # _____
1b. Who is the child's dentist? _____	[ ] if none, provide Dentist referral list
2. How often are your child's teeth brushed? [ ] Never [ ] Once a day [ ] Twice a day	

ALLERGY HISTORY

6. Does your child have an allergy or intolerance to:	Check the reaction for each allergy			
	Skin Rash	Upset Stomach	Swelling	Difficulty Breathing
Food/Formula*				
Other (Medicine, Insects, animals,etc)				

***Contact the Nutrition Clerk ASAP. Child may NOT attend center/socials until any necessary menu modifications are made.**

NUTRITIONAL HISTORY

1. How would you describe your child's eating? [ ] OK [ ] Picky [ ] Too Much [ ] Not Enough [ ] Other_____		
2. Does your child *often* have trouble: [ ] Chewing [ ] Swallowing [ ] Choking		
Explain:		
If at risk, child should be seated in teacher's direct line of sight. Ask parent if food modifcaiton is necessary.		
3. Is your child on a special diet?	Y N	If yes, what diet?***
***Contact the Nutrition Clerk ASAP. Child may NOT attend center/socials until any necessary menu modifications are made.		
4. Does your child have *frequent* or *severe* constipation?	Y N	Describe:
5. Does your child *often* have: [ ]Diarrhea [ ]Frequent urination [ ]Stomach pain [ ]Vomiting		
Describe:		
6. Does your child watch T.V. or play computer/video games? Hours/Day: _____	Y N	Recommend no TV for children under 2. Limit screen time to 1-2 hours/day for older children.
7. How much time does your child spend each day being physically active? Hours/Day:_____		Encourage at least 60 minutes physical activity daily.

SKILLS (ONLY APPLICABLE FOR CHILDREN 6 MONTHS AND OLDER)

1. Describe the texture of your child's food: [ ] Strained [ ] Ground [ ] Cut [ ] Regular

2. Describe your child's level of independence in feeding:
[ ] Feeds Self
[ ] Partially Independent (parent feeds some foods)
[ ] Dependent (parent feeds totally)

Age	Fine/Motor Gross Development
6 Mo	Drinking from a cup usually starts no later than 6-8
8 Mo	Finger foods usually start no later than 8-10
10 Mo	Self Spoon feeding usually starts no later than 10-12

3. What utensils does your child frequently use? [ ] Spoon [ ] Fork [ ] Knife [ ] Cup

FOOD AVAILABILITY

1. Are you receiving CalFresh (SNAP) benefits?	Y N	Check eligibility, Refer to SNAP.
2. Are you receiving WIC vouchers?	Y N	Check eligibility. Refer to WIC. Referral also occurs via Nutrition Clerk.
3. Do you want information on how to stretch food budget money farther?	Y N	Provide tips on how to manage food budget. Handout available.
4. Are you missing equipment to prepare family meals? Check missing items: [ ] Refrigerator [ ] Sink [ ] Oven [ ] Plates [ ] Running Water [ ] Eating Utensils [ ] Stove [ ] Pots/Pans		Possible assistant programs found in "Community Resources Guide" via HS Social Services.

SHASTA HEAD START HEALTH, DEVELOPMENTAL AND NUTRITIONAL ASSESSMENT (HDNA)

Complete for children over 12 months of age

Child's Name	DOB	Site	Date

1. How many times a day does your child eat: a meal: _____ a snack: _____	Encourage 3 well-spaced meals & 2-3 snacks daily.
2. How many times a day does your child drink water?	Encourage water over sweetend beverages

Check the ***one column*** that best describes ***how often*** this child eats each of the foods listed below.
Ask the parent to recall foods the child usually eats.
(Include meals and snacks eaten at home *and* away from home - school breakfasts, lunch, restaurants, etc.)

Group	Foods	Daily				Weekly			Intervention (Encourage consumption of more foods in this group)	Inadequate Servings
		1	2	3	More	0	1-2	3-4		
Milk GROW	**Milk** [ ]Whole [ ]2% [ ] 1% [ ]Other								If less than 3 servings per day at risk for inadequate: **CALCIUM & PROTEIN**	
	1-3 yr olds: Recommend 16oz milk or equivalent									
	4-5 yr olds: Recommend 18oz milk or equivalent									
	Cheese									
	Yogurt									
	Other/ Pudding/ Ice Cream									
Protein GROW	**Meat** (any kind)								If less than 2 servings per day at risk for inadequate: **IRON & PROTEIN.**	
	Fish									
	Eggs									
	Beans: baked beans, lentils, kidney, soy, garbanzo, tofu, black-eyed peas, etc									
	Peanut Butter									
	Nuts/ Seeds									
Grains GO	**Cereal** (any kind)								If less than 6 servings per day at risk for inadequate: **CARBS, CALORIES, IRON, & FIBER** (whole grains)	
	Bread/Tortilla									
	Crackers/ Popcorn									
	Rice/ Barley/ Pasta/ Noodles									
	Pancakes/ Waffles									
Vitamin C GLOW	**Vitamin C rich Fruit:** orange, grapefruit, lemon, cantaloupe, kiwi, mango, strawberry, pineapple								**If less than 6 servings per day at risk for inadequate FIBER, VARIETY, VITAMINS A & C.** Cantaloupe, tomato, broccoli, mango, & red peppers contain both **VITAMINS A & C.**	
	Tomato (or juice)									
	Cabbage/ Brussels Sprouts									
	Broccoli/ Peppers (red, green, chili)									
Vitamin A GLOW	**Dark Leafy Greens;** spinach, chard, kale, bok choy, lettuce, etc.									
	Carrots									
	Sweet Potatoes									
	Apricots									
	Squash: butternut, hubbard, or pumpkin									
Fruit/Veg GLOW	**Apples**									
	Bananas									
	Pears/ Peaches/ Nectarines									
	Raisins/ Plums/ Prunes/ Grapes									
	Corn/ Peas/ Snap Peas/ Green Beans									
	Potatoes									
	Lettuce/ Celery/ Artichokes/ Zucchini									
Extras	**Fruit Juice**								**None needed.** If more than 3 servings per day, at risk for: dental caries, overweight, low iron, low fiber, upset stomach, poor diet etc.	
	Candy/ Cookies/ Cake/ Pie/ Donuts									
	Popsicles									
	Caffiene (Soda, Iced tea, coffee) Recommend NO Caffiene									
	HI-C/ Punch/ Lemonade/ KoolAid									
	Sugar-Coated Cereal									
	Chips									