



Nutritionist Report WCMCA Head Start



FES Name and Center: _____

Head Start Child's Name: _____

Parent Name: _____

Type of Contact:

- Parent
- Staff
- Community Partner
- Professional
- Other: _____

Topic:

- Special Diet
- Food Allergy
- Likes/Dislikes
- Religious Preference
- Weight
- Adaptive Feeding
- Dietary Changes/Appetite
- Child Eating Non-Food Items
- Hemoglobin
- Medical Complications
- Consultation to/with Head Start Program
- Other: _____

Concerns, Questions, Discussion, Comments:

Plan/ Follow-Up:

Signed: _____

Date: _____