



Nutrition Tools



TOOL A

Nutrition Questionnaire for Infants

The nutrition questionnaire for infants is a tool for parents to complete before meeting with a health professional. The questionnaire provides a useful starting point for identifying areas of nutrition concern and determining whether additional screening is needed.

When reviewing responses to the questionnaire, use the following interpretive notes to identify areas of concern and determine follow-up questions or actions. The notes are numbered according to their corresponding questions on the questionnaire.

INTERPRETIVE NOTES

1. Feeding is crucial for the development of a healthy relationship between parents and their infant. A parent's responsiveness to an infant's cues of hunger and satiation and the close physical contact during feeding facilitate healthy social and emotional development.
2. Signs of hunger include hand-to-mouth activity, rooting, pre-cry facial grimaces, fussing sounds, reaching for utensils, and crying. Signs of fullness include turning the head away from the nipple, showing interest in things other than eating, playing with food, and closing the mouth.
3. Infants should be fed breast milk or iron-fortified infant formula, even in infant cereal. If infants are weaned from breast milk before age 12 months, they should be fed iron-fortified infant formula rather than cow's milk. Cow's milk, goat's milk, and soy milk are not recommended during the first 12 months of life.
4. In establishing realistic feeding goals for infants, it is important to assess an infant's developmental readiness for eating foods with different textures as well as her self-feeding skills. Before beginning to eat from a spoon, infants should be able to hold their heads upright and move their tongues from side to side.
5. Complementary (solid) foods can be introduced between ages 4 and 6 months when the infant is developmentally ready. After the infant has accepted iron-fortified infant cereal, then pureed or soft fruits, vegetables, and meats can be offered. Only one new food should be introduced at a time; parents should wait 3 to 5 days to see how the infant tolerates the food (observe for signs of allergic reaction). There is no research to support a particular order when introducing new foods.

Between ages 6 and 12 months, infants master chewing, swallowing, and manipulation of finger foods. They begin to use cups and utensils, and while they are experimenting with new tastes and textures, their sensory and perceptual development are stimulated.

6. Juice should not be given to infants younger than 6 months. After age 6 months, serve only 100% fruit juice in a cup instead of a bottle and limit it to 4 to 6 oz per day. It should be offered in small amounts (more than 6 oz per day is excessive), because too much juice may reduce the infant's appetite for other foods and increases the risk of loose stools and diarrhea.
7. Infants permitted to suck on a bottle of any fluid that contains carbohydrates, including juice and milk, for prolonged periods are at risk for developing dental caries (tooth decay). Infants should not be put to bed at night or at naptime with a bottle or allowed unlimited access to a bottle (ie, permitting the infant to carry a bottle around whenever he wants).
8. Honey should not be added to food, water, or formula that is fed to infants, because it can be a source of spores that cause botulism poisoning in infants. Processed foods containing honey should not be given to infants.
9. Starting at age 6 months, infants receiving breast milk only or infant formula prepared with water need fluoride supplementation if the water is severely deficient in fluoride. To assess fluoride levels, ask about all sources of water used by the family, including municipal, well, commercially bottled, and home system-processed water. In addition, find out whether any ready-to-feed infant formula used is manufactured with water that has little or no fluoride. Refer an infant who is not getting enough fluoride to a dentist or primary care health professional for follow-up.
- 10–11. If inadequate cooking or food-storage facilities adversely affect a family's nutrient intake, refer the family to social services. If a family does not have adequate resources to obtain food, refer them to nutrition assistance programs such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Supplemental Nutrition Assistance Program (SNAP) or to a community food shelf or pantry. (See Tool K: Federal Nutrition Assistance Programs.)
12. Respond to parents' questions and concerns.

TOOL A: NUTRITION QUESTIONNAIRE FOR INFANTS

1. How would you describe feeding time with your baby? *(Check all that apply.)*
 - Always pleasant
 - Usually pleasant
 - Sometimes pleasant
 - Never pleasant
2. How do you know when your baby is hungry or has had enough to eat?
3. What type of milk do you feed your baby, and how often? *(Check all that apply.)*
 - Breast milk
 - Iron-fortified infant formula
 - Evaporated milk
 - Whole milk
 - Reduced-fat (2%) milk
 - Low-fat (1%) milk
 - Fat-free (skim) milk
 - Goat's milk
 - Soy milk
4. What types of things can your baby do? *(Check all that apply.)*
 - Open mouth for breast or bottle
 - Drink liquids
 - Follow objects and sounds with eyes
 - Put hand in mouth
 - Sit with support
 - Bring objects to mouth and bite them
 - Hold bottle without support
 - Drink from a cup that is held
5. Does your baby eat solid foods? If yes, which ones?
6. Does your baby drink juice? If yes, how much?
7. Does your baby take a bottle to bed at night or carry a bottle around during the day?

8. Do you add honey to your baby's bottle or dip your baby's pacifier in honey?

9. What is the source of the water your baby drinks? Sources include public, well, commercially bottled, and home system-processed water.

10. Do you have a working stove, oven, and refrigerator where you live?

11. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?

12. What concerns or questions do you have about feeding your baby or how your baby is growing? Do you have any concerns or questions about your baby's weight?



TOOL B

Nutrition Questionnaire for Children Ages 1 to 10

The nutrition questionnaire for children is a tool for parents to complete before meeting with a health professional. The questionnaire provides a useful starting point for identifying areas of nutrition concern and determining whether additional screening is needed.

When reviewing responses to the questionnaire, use the following interpretive notes to identify areas of concern and to determine follow-up questions or actions. The notes are numbered according to their corresponding questions on the questionnaire.

INTERPRETIVE NOTES

1. Children grow more slowly from ages 1 to 5 than in infancy. Their appetites can change from day to day, depending on how fast they are growing and how active they are. As long as they are energetic and growing, they are probably getting enough of the nutrients they need. Young children often eat small portions. They should be offered small servings and should be allowed to ask for more.
Irregular eating and frequently missing meals can result in an insufficient intake of calories (energy) and nutrients. Busy schedules and inadequate resources for obtaining food may cause children to miss meals.
2. Encourage parents to eat meals together as a family. If children see their parents and other adults enjoying meals together and eating a variety of foods, they will want to do the same. Explain that being a role model is the best way to teach. Allow children to engage in age-appropriate meal preparation activities, such as washing vegetables or helping to prepare a side dish.
3. During mealtimes, a relaxed atmosphere should be maintained, and parents should make an effort not to rush children. Encourage parents to get rid of distractions such as television during meals. Well-balanced meals and snacks should be offered in a pleasant environment. When children are stubborn about eating, it is often their way of learning to be independent. Fighting over food may make them even more stubborn.

4. Children need between 4 and 6 meals and snacks each day; these should be offered at scheduled times and should consist of a variety of healthy foods. Children should be allowed to decide whether and how much to eat at each meal or snack; they should not be pressured to eat certain foods or rewarded for eating certain foods.
5. Children ages 2 to 3 need the same variety of foods and the same number of servings as older children but may need smaller portions—about two-thirds of a serving for each serving that older children eat. By the time children are 4 years old, they need serving sizes similar to those eaten by older family members: 1 slice of bread; 1 cup of raw vegetables; 1 medium-sized piece of fruit; 1 cup of milk or yogurt; and 2 to 3 oz of cooked lean meat, poultry, or fish.

Grains. Grain products provide vitamins, minerals, complex carbohydrates, and dietary fiber, which are important for good health. Children need 3 to 6 oz (6–11 servings) per day of grains, of which at least half should be whole grains.

Vegetables. Vegetables are an important source of many nutrients, including potassium; folic acid; vitamins A, E, and C; and fiber. Children need 1 to 2½ cups (3–5 servings) per day.

Fruits. Fruits provide vitamins, minerals, and dietary fiber. Children need 1 to 1½ cups (2–4 servings) per day. Many juice beverages are not 100% juice. Parents need to check the ingredients to make sure that they purchase juice without added sugar such as corn syrup. If parents purchase canned or packaged fruits, they should choose varieties with little or no added sugar.

Milk and milk products. Milk, yogurt, cheese, and other milk products supply calcium for building and maintaining strong bones and teeth and protecting bones from osteoporosis. Children need 2 to 3 servings per day. Children ages 1 to 2 need whole milk. After age 2, children should gradually increase the proportion of low-fat foods in their diets. For children older than 2, low-fat (1%) or fat-free

(skim) milk is recommended. Reduced-fat milk (2%) is recommended for children ages 1 to 2 years for whom obesity is a concern or who have a family history of obesity, dyslipidemia, or cardiovascular disease.

Meat and meat alternatives. Meat and meat alternatives include both animal and plant sources of protein, iron, and other important nutrients. Children need 2 to 5 oz (2–3 servings) per day. Between 2 and 3 oz of cooked lean meat, poultry, or fish equal one serving from this group. One egg or ½ cup of cooked dry beans counts as 1 oz of lean meat; 2 tablespoons of peanut butter count as 1 oz of meat.

Fats and sweets. This group includes butter, margarine, mayonnaise, vegetable oil, gravy, salad dressing, cake/cupcakes, pie, cookies, chips, doughnuts, and candy. There is no recommended serving. Consumption of fats and sweets should be limited. If allowed to consume sweets in unlimited amounts, children are likely to fill up on these rather than eat healthy foods.

6. For children younger than 3, foods that may cause choking need to be avoided (eg, hard or chewy candy, mini-marshmallows, popcorn, pretzels, chips, spoonfuls of peanut butter, nuts, seeds, large chunks of meat, hot dogs, raw carrots, raisins and other dried fruits, whole grapes).

Young children, especially 3-year-olds, are at risk for choking on food and remain at risk until they can chew and swallow better (at about age 5).

Precautions to prevent choking include

- Staying with children while they are eating.
- Having children sit while eating, because eating while walking or running can cause choking.
- Keeping things calm during meal or snack times, because becoming excited while eating can cause choking.
- Observing children who have received rub-on teething medications, because these medications may affect chewing and swallowing.

TOOL B: NUTRITION QUESTIONNAIRE FOR CHILDREN AGES 1 TO 10

1. How would you describe your child's appetite?
- Good
- Fair
- Poor
2. How many days per week does your family eat meals together?

3. How would you describe mealtimes with your child?
- Always pleasant
- Usually pleasant
- Sometimes pleasant
- Never pleasant
4. How many meals does your child eat per day? How many snacks?

5. Which of these foods did your child eat or drink last week? (*Check all that apply.*)

Grains

- Bagels
- Bread
- Cereal/grits
- Crackers
- Muffins
- Noodles/pasta/rice
- Rolls
- Tortillas
- Other grains: _____

Vegetables

- Broccoli
- Carrots
- Corn
- Green beans
- Green salad
- Greens (collard, spinach)
- Peas
- Potatoes
- Tomatoes
- Other vegetables: _____

Fruits

- Apples/juice
- Bananas
- Grapefruit/juice
- Grapes/juice
- Melon
- Oranges/juice
- Peaches
- Pears
- Other fruits/juice: _____

Milk and Milk Products

- Fat-free (skim) milk
- Low-fat (1%) milk
- Reduced-fat (2%) milk
- Whole milk
- Flavored milk
- Cheese
- Ice cream
- Yogurt
- Other milk and milk products: _____

Meat and Meat Alternatives

- Beef/hamburger
- Chicken
- Cold cuts/deli meats
- Dried beans (for example, black beans, kidney beans, pinto beans)
- Eggs
- Fish
- Peanut butter/nuts
- Pork
- Sausage/bacon
- Tofu
- Turkey
- Other meat and meat alternatives: _____

Fats and Sweets

- Cake/cupcakes
- Candy
- Chips
- French fries
- Cookies
- Doughnuts
- Fruit-flavored drinks
- Pie
- Soft drinks
- Other fats and sweets: _____

6. If your child is 5 years or younger, does he or she eat any of these foods? (*Check all that apply.*)
- Hot dogs
 - Marshmallows
 - Nuts and seeds
 - Peanut butter
 - Popcorn
 - Pretzels and chips
 - Raisins
 - Raw celery or carrots
 - Hard or chewy candy
 - Whole grapes
7. How much juice does your child drink per day? How much sweetened beverage (for example, fruit punch or soft drinks) does your child drink per day?
8. Does your child take a bottle to bed at night or carry a bottle around during the day?
- Yes No
9. What is the source of the water your child drinks? Sources include public, well, commercially bottled, and home system-processed water.
10. Do you have a working stove, oven, and refrigerator where you live?
- Yes No
11. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?
12. Did you participate in physical activity (for example, walking or riding a bike) in the past week?
- Yes No
- If yes, on how many days and for how many minutes or hours per day? _____
13. Does your child spend more than 2 hours per day watching television and DVDs or playing computer games?
- Yes No
- If yes, how many hours per day? _____
14. Does the family watch television during meals?
- Yes No
15. What concerns or questions do you have about feeding your child or how your child is growing? Do you have any concerns or questions about your child's weight?



TOOL C

Nutrition Questionnaire for Adolescents Ages 11 to 21

The nutrition questionnaire for adolescents is a tool for adolescents or parents to complete before meeting with a health professional. The questionnaire provides a useful starting point for identifying areas of nutrition concern and determining whether additional screening is needed.

When reviewing responses to the questionnaire, use the following interpretive notes to identify areas of concern and determine follow-up questions or actions. The notes are numbered according to their corresponding questions on the questionnaire.

INTERPRETIVE NOTES

EATING BEHAVIORS

- 1–2. Irregular eating and frequently missing meals can result in a low intake of calories (energy) and nutrients. Busy schedules and inadequate resources for obtaining food may cause an adolescent to miss meals. Reinforce the importance of eating 3 meals instead of frequent snacks per day.
3. Adolescents who are on their own for most meals—perhaps because of a busy schedule—may not have healthy eating behaviors. Remind adolescents and parents that family meals ensure optimal nutrition and encourage communication. Explain to parents that family meals give them the opportunity to model healthy eating behaviors.
4. Shopping for and preparing food give adolescents the opportunity to learn about healthy food choices. Make sure the adolescent is familiar with the basic rules of food safety. (See Tool H: Basics for Handling Food Safely.)

5. Consumption of convenience and fast foods is common among Americans. Frequent consumption increases fat, caloric, and sodium intake and reduces the intake of certain vitamins and minerals. Suggest that adolescents limit the consumption of these foods, and offer suggestions for making healthier food choices when eating away from home.
6. If the adolescent is on a special diet, ask, “What kind of diet are you on?” This will provide an opportunity to evaluate the adolescent’s dietary management of conditions such as diabetes mellitus or food allergies. Refer to a registered dietitian, if appropriate.
7. Individuals’ interpretations of the meaning of the term *vegetarian* can vary greatly. Ask adolescents who are vegetarian to name the foods they eliminate from their diet as a vegetarian. Further dietary assessment is recommended.
8. Changes (either increases or decreases) in weight or appetite may indicate depression or other emotional stress, and they warrant further assessment. Changes in weight or appetite may also indicate that an adolescent is engaging in restrictive dieting or disordered eating, which may predispose them to an eating disorder. Detailed dietary and psychological assessments are recommended.
9. Soft drinks, fruit-flavored drinks, sports drinks, energy drinks, and recovery drinks may displace healthier beverages (eg, milk, which provides calcium, protein, and vitamins; orange juice, which is an important source of vitamin C and folate).

Food Choices

10. *Grains*. Grains supply complex carbohydrates (which are important sources of energy), protein, and minerals; they also tend to be low in fat. Whole grains are a good source of dietary fiber. Six to 11 servings (5–7 oz) of grains per day are recommended; at least half of these servings should be whole grains.

Vegetables. Vegetables are an important source of many nutrients, including potassium; folic acid; vitamins A, E, and

C; and fiber. Two to 3 cups of vegetables per day are recommended, depending on age and gender.

Fruits. Fruits are important sources of vitamins and fiber and are low in fat. Citrus fruits and juices, strawberries, and cantaloupe are good sources of vitamin C and folate. One and one-half to 2 cups of fruits per day are recommended, based on age and gender.

Milk and milk products. Milk, yogurt, and cheese are good sources of calcium and provide protein, vitamins, and minerals. Three or more servings per day of milk and milk products are recommended. Encourage the adolescent to consume reduced-fat (2%), low-fat (1%), or fat-free (skim) milk and other lower-fat milk products. Adequate calcium intake during adolescence is essential for peak bone mass development. If the recommended calcium intake cannot be met by diet, a supplement may be warranted. Of the various forms of calcium, calcium carbonate contains the highest proportion (40%) of elemental calcium by weight.

Meat and meat alternatives. Red meat, poultry, fish, eggs, and dried beans provide protein, iron, zinc, and many other minerals and vitamins. Adequate protein intake is essential for growth and development. Two to 3 servings (or 5–6 oz) of meat or meat alternatives per day are recommended. Cold cuts, bacon, sausage, and fried meats are high in fat and calories; therefore, their consumption should be limited.

Fats and sweets. This group includes butter, margarine, mayonnaise, vegetable oil, gravy, salad dressing, cake, cupcakes, pie, cookies, chips, doughnuts, and candy. There is no recommended serving because consumption of fats and sweets should be limited.

Food Resources

- 11–12. If inadequate cooking or food-storage facilities adversely affect a family’s nutrient intake, refer the family to social services. If a family does not have adequate resources to obtain food, refer the family to nutrition assistance programs such

as the National School Lunch Program (NSLP) and the Supplemental Nutrition Assistance Program (SNAP), or to a community food shelf or pantry. (See Tool K: Federal Nutrition Assistance Programs.)

Weight and Body Image

13. Some adolescents may be dissatisfied with their weight and use unhealthy means to alter it. If the adolescent expresses a concern about weight, follow up with questions such as “How would you classify your weight?” or “Are you doing anything to try to change your weight?”
14. If the adolescent is dieting, determine the frequency, duration, and methods of weight loss. Chronic food restriction and inadequate energy intake may cause poor growth, delayed sexual development, menstrual irregularities, poor concentration, irritability, sleep difficulties, and constipation. Frequent dieting may be associated with binge eating. Purging (eg, self-induced vomiting, laxative use) may be associated with other risk behaviors (eg, substance use, suicide attempts).
15. Self-induced vomiting; the use of laxatives, diuretics, or diet pills; or both are warning signs of eating disorders. Adolescents who engage in these behaviors need further assessment.

Physical Activity

16. Adolescents can achieve substantial health benefits by doing moderate- and vigorous-intensity physical activity for a total of 60 minutes or more each day. This should include aerobic activity as well as age-appropriate muscle- and bone-strengthening (weight-bearing) activities. The benefits of physical activity include giving adolescents a feeling of accomplishment, reducing the risk of certain diseases (eg, diabetes mellitus, hypertension) if they continue to be active during adulthood, and promoting mental health. Help the inactive adolescent identify enjoyable activities and incorporate them into a daily routine.

Some adolescents engage in physical activity to compensate for caloric intake as a form of purging. Excessive physical activity (>2 hours per day) may lead

to fatigue, loss of appetite, or menstrual irregularities and may be a sign of an eating disorder.

Lifestyle

17. Adolescents who spend too much time watching television and DVDs or playing computer games are likely to have a sedentary lifestyle, which can lead to overweight. These sedentary activities should be limited to 1 to 2 hours per day.
18. Watching television during mealtimes is a distraction that prevents family interaction and interferes with a child’s eating. Value the time spent together while eating. Often it is the only time during the day that families can be together.
19. If the adolescent uses vitamin, mineral, herbal, or other dietary supplements, ask about the kind, dosage, length of use, and reason for use. Encourage the adolescent to eat healthy foods instead of using supplements to obtain nutrients. If the adolescent is interested in vitamin supplements, emphasize the importance of using low-dose supplements and the need to avoid high doses (particularly of vitamin A), which can be toxic.

Adolescents who engage in physical activities in which strength is a critical factor (eg, football, weightlifting) may consume a high-protein diet or take protein supplements in an attempt to increase strength and muscle mass. However, increased protein intake does not affect muscle size.

Adolescents who use protein supplements should be asked about anabolic steroid use. Some adolescents take anabolic steroids to enhance their strength, muscle size, and endurance. Steroid use can cause side effects, including acne, deepening of the voice, and hair recession.

20. Unhealthy behaviors occur in clusters in adolescents. For example, adolescents who smoke are more likely to have unhealthy eating behaviors and low levels of physical activity. Adolescents who smoke to lose weight need counseling on both smoking and healthy weight management. Cigarette smoking also increases the need for vitamin C.

21. If the adolescent admits to using alcohol or street drugs, screen for substance abuse, and refer for counseling and treatment. (Refer to CRAFFT, a behavioral health screening tool for use with children and adolescents younger than 21).

Some adolescents take anabolic steroids to enhance their strength, muscle size, and endurance. Steroid use can cause side effects, including acne, deepening of the voice, and hair recession. Emphasize the dangers of steroid use to adolescents who engage in strenuous physical activity to build muscle or who participate in sports in which strength is a critical factor (eg, football, weightlifting).

TOOL C: NUTRITION QUESTIONNAIRE FOR ADOLESCENTS AGES 11 TO 21

1. Which of these meals or snacks did you eat yesterday? (*Check all that apply.*)

- Breakfast
 Lunch
 Dinner or supper
 Morning snack
 Afternoon snack
 Evening/late-night snack

2. Do you skip breakfast 3 or more times a week?

- Yes No

Do you skip lunch 3 or more times a week?

- Yes No

Do you skip dinner or supper 3 or more times a week?

- Yes No

3. Do you eat dinner or supper with your family 4 or more times a week?

- Yes No

4. Do you fix or buy the food for any of your family's meals?

- Yes No

5. Do you eat or take out a meal from a fast-food restaurant 2 or more times a week?

- Yes No

6. Are you on a special diet for medical reasons?

- Yes No

7. Are you a vegetarian?

- Yes No

8. Do you have any problems with your appetite, like not feeling hungry, or feeling hungry all the time?

- Yes No

9. Which of the following did you drink last week? (*Check all that apply.*)

- Tap or bottled water
 Fitness water
 Juice
 Regular soft drinks
 Diet soft drinks
 Fruit-flavored drinks
 Sports drinks
 Energy drinks
 Recovery drinks

- Fat-free (skim) milk
 Low-fat (1%) milk
 Reduced-fat (2%) milk
 Whole milk
 Flavored milk (for example, chocolate, strawberry)
 Coffee or tea
 Beer, wine, or hard liquor

10. Which of these foods did you eat last week? (*Check all that apply.*)

Grains

- Bagels
 Bread
 Cereal or grits
 Crackers
 Muffins
 Noodles, pasta, or rice
 Rolls
 Tortillas
 Other grains: _____

Vegetables

- Broccoli
 Carrots
 Corn
 Green beans
 Green salad
 Greens (collard, spinach)
 Peas
 Potatoes
 Tomatoes
 Other vegetables: _____

Fruits

- Apples or apple juice
 Bananas
 Grapefruits or grapefruit juice
 Grapes or grape juice
 Melon
 Oranges or orange juice
 Peaches
 Pears
 Other fruits or other fruit juice: _____

Milk and Milk Products

- Fat-free (skim) milk
 Low-fat (1%) milk
 Reduced-fat (2%) milk
 Whole milk
 Flavored milk
 Cheese

- Ice cream
- Yogurt
- Other milk and milk products: _____

Meat and Meat Alternatives

- Beef or hamburger
- Chicken
- Cold cuts/deli meats
- Dried beans (for example, black beans, kidney beans, pinto beans)
- Eggs
- Fish
- Peanut butter or nuts
- Pork
- Sausage or bacon
- Tofu
- Turkey
- Other meat and meat alternatives: _____

Fats and Sweets

- Cake or cupcakes
- Candy
- Chips
- French fries
- Cookies
- Doughnuts
- Fruit-flavored drinks
- Pie
- Soft drinks
- Other fats and sweets: _____

11. Do you have a working stove, oven, and refrigerator where you live?
 Yes No
12. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?
 Yes No
13. Are you concerned about your weight?
 Yes No
14. Are you on a diet now to lose weight or to maintain your weight?
 Yes No
15. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or not eating?
 Yes No
16. Did you participate in physical activity (for example, walking or riding a bike) in the past week?
 Yes No
- If yes, on how many days and for how many minutes or hours per day? _____
17. Do you spend more than 2 hours per day watching television and DVDs or playing computer games?
 Yes No
- If yes, how many hours per day? _____
18. Does the family watch television during meals?
 Yes No
19. Do you take vitamin, mineral, herbal, or other dietary supplements (for example, protein powders)?
 Yes No
20. Do you smoke cigarettes or chew tobacco?
 Yes No
21. Do you ever use any of the following?
(Check all that apply.)
- Alcohol, beer, or wine
 - Steroids (without a doctor's permission)
 - Street drugs (marijuana, speed, crack, or heroin)



TOOL D

Key Indicators of Nutrition Risk for Children and Adolescents

INDICATORS OF NUTRITION RISK	RELEVANCE	CRITERIA FOR FURTHER SCREENING AND ASSESSMENT
Food Choices		
Consumes <2 servings of fruits per day. Consumes <3 servings of vegetables per day.	Fruits and vegetables provide vitamins (such as A and C), minerals, and fiber. Low intake of fruits and vegetables is associated with an increased risk of many types of cancer.	Assess the child or adolescent who is consuming <1 serving of fruit per day. Assess the child or adolescent who is consuming <2 servings of vegetables per day.
Consumes <6 servings of cereal, bread, crackers, pasta, rice, or other pasta per day. Consumes <3 servings of whole grains per day.	Grain products provide complex carbohydrates, vitamins, minerals, and fiber. Low intake of fiber is associated with constipation and increased risk of colon cancer.	Assess the child or adolescent who is consuming <6 servings of cereal, bread, crackers, rice, pasta, or other grains per day. Assess the child or adolescent who is consuming <3 servings of whole-grain cereal, bread, crackers, rice, pasta, or other grains per day Assess the child or adolescent who has recent history of constipation.

**TOOL D: KEY INDICATORS OF NUTRITION RISK FOR CHILDREN
AND ADOLESCENTS, CONTINUED**

INDICATORS OF NUTRITION RISK	RELEVANCE	CRITERIA FOR FURTHER SCREENING AND ASSESSMENT
Food Choices, continued		
<p>For children <9: Consumes <2 servings of milk and milk products per day.</p> <p>For children ages ≥9 and adolescents: Consumes <3 servings of milk and milk products per day.</p>	<p>Milk and milk products are a good source of protein, vitamins, and calcium and other minerals. Low intake of milk and milk products may reduce peak bone mass and increase the risk of osteoporosis.</p>	<p>Assess the child (<9) who is consuming <1 serving of milk and milk products per day.</p> <p>Assess the child (≥9) or adolescent who is consuming <2 servings of milk and milk products per day.</p> <p>Assess the child or adolescent who has a milk allergy or is lactose intolerant.</p> <p>Assess the child or adolescent who is consuming >2 soft drinks per day.</p>
<p>Consumes <2 servings of meat or meat alternatives (eg, beans, eggs, nuts, seeds) per day.</p>	<p>Protein-rich foods (eg, meats, meat alternatives) are good sources of B vitamins, iron, and zinc. Low intake of protein-rich foods may impair growth and increase the risk of iron-deficiency anemia and of delayed growth and sexual maturation. Low intake of meat or meat alternatives may indicate inadequate availability of these foods at home. Special attention should be paid to children and adolescents who follow a vegetarian diet.</p>	<p>Assess the child or adolescent who is consuming <1 serving of meat or meat alternatives per day.</p>
<p>For children ≥5: Consumes excessive amount of fat.</p>	<p>Excessive intake of dietary fat contributes to the risk of cardiovascular disease and obesity and is associated with some cancers.</p>	<p>Assess the child or adolescent who has a family history of premature cardiovascular disease.</p> <p>Assess the child or adolescent if body mass index (BMI) is ≥85th percentile.</p>
Eating Behaviors		
<p>Exhibits poor appetite.</p>	<p>A poor appetite may be developmentally appropriate for young children, but in older children and adolescents it may indicate depression or other emotional stress, or a chronic disease.</p>	<p>Assess the child or adolescent if BMI is <15th percentile or if weight loss has occurred.</p> <p>Assess the child or adolescent if irregular menses or amenorrhea has occurred for ≥3 months.</p> <p>Assess the child or adolescent for organic and psychiatric disease.</p>

**TOOL D: KEY INDICATORS OF NUTRITION RISK FOR CHILDREN
AND ADOLESCENTS, CONTINUED**

INDICATORS OF NUTRITION RISK	RELEVANCE	CRITERIA FOR FURTHER SCREENING AND ASSESSMENT
Eating Behaviors, continued		
Consumes food from fast-food restaurants ≥ 3 times per week.	Excessive consumption of convenience foods and foods from fast-food restaurants is associated with high fat, calorie, and sodium intake, as well as low intake of certain vitamins and minerals.	Assess the child or adolescent who is overweight or obese or who has diabetes mellitus, hyperlipidemia, or other conditions requiring reduction in dietary fat.
Skips breakfast, lunch, or dinner or supper ≥ 3 times per week.	Meal-skipping is associated with a low intake of energy and essential nutrients and, if it is a regular practice, could compromise growth and development. Repeatedly skipping meals decreases the nutritional adequacy of the diet.	Assess the child or adolescent to ensure that meal-skipping is not due to inadequate food resources or unhealthy weight-loss practices.
Has food jags—eats one particular food only.	Food jags, which limit the variety of food consumed, decrease the nutritional adequacy of the diet.	Assess the child's or adolescent's dietary intake over several days.
Food Resources		
Has inadequate financial resources to buy food, insufficient access to food, or lack of access to cooking facilities.	Poverty can result in hunger and compromised food quality and nutrition status. Inadequate dietary intake interferes with learning.	Assess the child or adolescent who is from a family with low income, is homeless, or is a runaway.
Weight and Body Image		
Practices unhealthy behaviors (eg, chronic dieting; vomiting; and using laxatives, diuretics, or diet pills to lose weight).	Chronic dieting is associated with many health concerns (eg, fatigue, impaired growth and sexual maturation, irritability, poor concentration, impulse to binge) and can lead to eating disorders. Frequent dieting in combination with purging is associated with health-compromising behaviors (eg, substance use, suicidal behaviors). Purging is associated with serious medical complications.	Assess the child or adolescent for eating disorders. Assess the child or adolescent for organic and psychiatric disease.
Is excessively concerned about body size or shape.	Eating disorders are associated with significant health and psychosocial morbidity. Eighty-five percent of all cases of eating disorders begin during adolescence. The earlier adolescents are treated, the better their long-term prognosis.	Assess the child or adolescent for distorted body image and dysfunctional eating behaviors, especially if the child or adolescent wants to lose weight but BMI is < 85 th percentile.
Exhibits significant weight change in past 6 months.	Significant weight change during the past 6 months may indicate stress, depression, organic disease, or an eating disorder.	Assess the child or adolescent to determine the cause of weight loss or weight gain (eg, limited or too much access to food, poor appetite, meal-skipping, eating disorder).

**TOOL D: KEY INDICATORS OF NUTRITION RISK FOR CHILDREN
AND ADOLESCENTS, CONTINUED**

INDICATORS OF NUTRITION RISK	RELEVANCE	CRITERIA FOR FURTHER SCREENING AND ASSESSMENT
Growth		
Has BMI <5th percentile.	Thinness may indicate an eating disorder or poor nutrition.	Assess the child or adolescent for eating disorders. Assess the child or adolescent for organic or psychiatric disease. Assess the child or adolescent for inadequate food resources.
Has BMI >85th percentile.	Overweight children and adolescents are more likely to be overweight adults and are at increased risk for health problems as adults. Obesity is associated with elevated cholesterol levels and elevated blood pressure. Obesity is an independent risk factor for cardiovascular disease and type 2 diabetes mellitus.	Assess the child or adolescent who is at risk for overweight.
Physical Activity		
Is physically inactive: participates in physical activity <5 days per week.	Lack of physical activity is associated with overweight and obesity, fatigue, and poor muscle tone in the short term, and a greater risk of cardiovascular disease in the long term. Regular physical activity reduces the risk of cardiovascular disease, hypertension, colon cancer, and type 2 diabetes mellitus. Weight-bearing physical activity is essential for normal skeletal development during childhood. Regular physical activity is necessary for maintaining normal muscle strength, joint structure, and joint function; contributes to psychological health and well-being; and facilitates weight reduction and weight maintenance throughout life.	Assess how much time the child or adolescent spends watching television or DVDs and playing computer games. Assess the child's or adolescent's definition of physical activity.

**TOOL D: KEY INDICATORS OF NUTRITION RISK FOR CHILDREN
AND ADOLESCENTS, CONTINUED**

INDICATORS OF NUTRITION RISK	RELEVANCE	CRITERIA FOR FURTHER SCREENING AND ASSESSMENT
Participates in excessive physical activity.	Intense physical activity nearly every day, sometimes more than once a day, can be unhealthy and may be associated with menstrual irregularity, excessive weight loss, and malnutrition.	Assess the child or adolescent for eating disorders.
Lifestyle		
Engages in heavy alcohol, tobacco, and other drug use.	Alcohol, tobacco, and other drug use can adversely affect nutrient intake and nutrition status.	Assess the child or adolescent further for alcohol, tobacco, and other drug use.
Uses dietary supplements.	Dietary supplements (eg, vitamin and mineral preparations) can be healthy additions to a diet for children or adolescents with a history of iron-deficiency anemia; however, high doses can have serious side effects. Adolescents who use supplements to “bulk up” may be tempted to experiment with anabolic steroids.	Assess the child or adolescent for the type of supplements used and dosage. Assess adolescent’s use of anabolic steroids and mega doses of other supplements.



TOOL E

Screening for Elevated Blood Lead Levels

Lead is a common environmental contaminant, and exposure to lead is a preventable risk that exists in all areas of the United States. Children ages 1 through 5 have the highest prevalence of elevated blood lead levels (defined as $\geq 10 \mu\text{g}/\text{dL}$).¹ According to National Health and Nutrition Examination Survey 1999–2002 data, 1.6% of children ages 1 through 5 had elevated blood lead levels during the study period; the highest prevalence of all age groups.² Blood lead levels as low as $10 \mu\text{g}/\text{dL}$ have been associated with adverse effects on cognitive development, growth, and behavior among children ages 1 through 5.³ High blood levels (ie, $\geq 70 \mu\text{g}/\text{dL}$) can cause serious health problems, including seizures, comas, and even death.³

The Centers for Disease Control and Prevention (CDC) published guidance to help health professionals working in state and local public health agencies determine which children are at risk for elevated blood lead levels and are most likely to benefit from lead screening.¹ The American Academy of Pediatrics (AAP) supports these guidelines. The following information has been compiled from CDC and AAP guidelines.^{1,4,5} The Centers for Medicare & Medicaid requires that all children enrolled in Medicaid be screened, because they are at greater risk for elevated blood lead levels than non-enrolled children.

RISK FACTORS

Children are at the greatest risk for elevated blood lead levels due to their hand-to-mouth activity, the increased potential for gastrointestinal absorption, and the vulnerability of the central nervous system during the developmental period.⁶ Risk factors for elevated blood lead levels among children include^{4,6,7}

- Minority race or ethnicity
- Recent immigration or adoption
- From family with low income
- Live in an urban area
- Live in home built prior to 1950
- Live in home recently renovated or remodeled
- Exposure to lead-contaminated dust or soil
- Exposure to lead-glazed pottery

- Exposure to lead-based toys, crayons, or cosmetics
- Folk remedy use
- Parents exposed to lead
- Pica
- Iron deficiency
- Developmental delay with oral behaviors
- Abused or neglected

SCREENING

Because children with elevated blood lead levels in the 10 to 25 µg/dL range do not develop clinical symptoms, screening is necessary to identify those who need environmental or medical intervention to reduce their blood lead levels.⁴

To prevent lead poisoning, health professionals should screen children for elevated blood lead levels at age 12 months and consider them again at age 24 months when blood lead levels peak (Box 1), except in communities with sufficient data to conclude that children are not at risk for lead exposure. In addition, health professionals should assess children's risk for elevated blood lead levels at ages 6, 9, and 18 months and at ages 3, 4, 5, and 6 years. If a child tests positive, appropriate action should follow.⁵

BOX 1. SCREENING FOR LEAD EXPOSURE IN CHILDREN^{a,b}

1. Does your child live in or regularly visit a home or child-care facility that was built before 1950?
2. Does your child live in or regularly visit a home or child-care facility built before 1978 that is being or has recently been renovated or remodeled (within the last 6 months)?
3. Does your child have a sibling or playmate who has or did have lead poisoning?

^aSource: American Academy of Pediatrics Committee on Environmental Health.⁴

^bAdditional or different questions may be needed based on specific local exposures.

SCREENING FOR CHILDREN ENROLLED IN MEDICAID

Blood lead level screening is required at age 1 and 2 years for all children who are enrolled in Medicaid as part of prevention services provided through the Early and Periodic Screening, Diagnosis, and Treatment program. All children ages 36 to 72 months who have not been previously screened must also receive a blood lead test. Children with elevated blood lead levels require further evaluation and appropriate follow-up care.⁸

ANTICIPATORY GUIDANCE

Health professionals should provide anticipatory guidance on lead exposure to parents of all infants and young children, including information on risk factors and specific prevention strategies (Table 1).⁴

- Discuss with parents sources of lead, and help them identify sources of lead in their child's environment.
- Obtain an environmental and family occupational history, and educate parents about the most common sources of childhood lead exposure for their child and in their community.
- Encourage parents to identify lead hazards and sources in their homes and to reduce their child's potential for exposure to lead.
- Warn parents about the dangers posed by unsafe renovation methods, and explain that they need to be cognizant of the possibility of new and reemerging sources of lead in children's environments.
- Direct parents to local, state, and federal agencies and organizations for information, particularly concerning methods to identify and safely repair lead hazards.⁹
- Discuss with parents the potential impact of lead on child development, and promote strategies that foster optimal development, including providing nurturing and enriching experiences.
- For all children from families with low incomes living in areas where exposure to lead is likely, promote participation in early enrichment programs, regardless of the child's blood lead levels.⁹

TABLE 1. RISK FACTORS AND PREVENTION STRATEGIES FOR LEAD EXPOSURE IN CHILDREN^a

Risk Factor	Prevention Strategy
Environmental	
Lead-based paint	Identify and abate.
Home renovation	Ensure the proper containment of building hazards and proper ventilation.
Buying or renting a new home	Inquire about lead hazards.
Dust	Use a wet mop to clean; wash hands frequently.
Hobbies	Ensure the proper use, storage, and ventilation of materials.
Soil	Restrict play in area; plant ground cover; wash hands frequently.
Drinking water	Flush water for 2 minutes before using in morning; use cold water for cooking, drinking.
Old ceramic or pewter cookware, old urns/kettles	Avoid use.
Some imported toys, crayons, or cosmetics	Avoid use.
Folk remedies	Avoid use.
Parental occupations	Remove work clothing at work.
Host	
Hand-to-mouth activity (or pica)	Wash hands frequently.
Inadequate nutrition	Ensure that diet is high in iron and calcium and low in fat; eat frequent small meals.
Developmental disabilities	Screen frequently for lead exposure.

^aSource: American Academy of Pediatrics Committee on Nutrition.⁴

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TOOL F

Stages of Change—A Model for Nutrition Counseling

STAGE	DESCRIPTION	GOALS	STRATEGIES
Precontemplation	Is unaware of problem and hasn't thought about change. Has no intention of taking action within the next 6 months.	Increase awareness of need for change. Personalize information on risks and benefits.	Create supportive climate for change—allow person to discuss feelings. Discuss personal aspects and health consequences of poor eating or sedentary behavior. Assess knowledge, attitudes, and beliefs. Build on existing knowledge.
Contemplation	Intends to take action within the next 6 months.	Increase motivation and confidence to perform the new behavior.	Identify problematic behaviors. Prioritize behaviors to change. Discuss benefits of behavior change. Identify personal motivational factors. Emphasize positive skills participant demonstrates that support change. Identify barriers to change and possible solutions.
Preparation	Intends to take action within the next 30 days and has taken some behavioral steps in this direction.	Initiate change.	Assist in developing a concrete action plan. Discuss earlier attempts to change and ways to succeed. Suggest initial small, achievable steps to make a change. Provide praise for the positive steps already taken. Elicit support from family and friends.

TOOL F: STAGES OF CHANGE—A MODEL FOR NUTRITION COUNSELING, CONTINUED

STAGE	DESCRIPTION	GOALS	STRATEGIES
Action	Has changed behavior for <6 months.	Commit to change.	Reinforce decision. Reinforce self-confidence. Provide education, resources, and referrals. Assist with self-monitoring, feedback, problem-solving, social support, and reinforcement. Discuss relapse and coping strategies.
Maintenance	Has changed behavior for >6 months.	Reinforce commitment and continue changes and new behaviors.	Plan follow-up to support changes. Help prevent relapse. Assist in coping, reminding, finding alternatives, and avoiding slips and relapses. Encourage addition of more challenging behavior changes if successful with initial changes.

^aAdapted from: Rimer and Glanz¹ and Sandoval et al.²

REFERENCES

1. Rimer B, Glanz K. *Theory at a Glance: A Guide for Health Promotion Practice*. 2nd ed. Bethesda, MD: National Institutes of Health, National Cancer Institute; 2005
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TOOL G

Strategies for Health Professionals to Promote Healthy Eating Behaviors

Tool G: Strategies for Health Professionals to Promote Healthy Eating Behaviors

STRATEGIES	APPLICATIONS/QUESTIONS
Communication Factors	
Promote positive, nonjudgmental strategies to help the child or adolescent adopt healthy eating behaviors.	Reinforce positive aspects of the child's or adolescent's eating behaviors.
Encourage the child's or adolescent's active participation in changing eating behaviors.	Help the child or adolescent identify barriers that make it difficult to change eating behaviors, and develop a plan of action for adopting new behaviors.
Provide concrete learning situations.	Use charts, food models, and videotapes to reinforce verbal information and instructions.
Focus on the short-term benefits of healthy eating behaviors.	Emphasize that healthy eating behaviors will make the child or adolescent feel good and have more energy.
Understand and respect the child's or adolescent's cultural eating behaviors.	Help the child or adolescent integrate cultural eating behaviors with dietary recommendations.
Use simple terminology.	Avoid using the term <i>diet</i> with the child or adolescent because it tends to be associated with weight loss and may be confusing.
Environmental Factors	
Create an office or clinic environment oriented to children or adolescents.	Use posters and materials written for children or adolescents.
Communicate developmentally appropriate health messages.	Use posters and materials that highlight the importance of healthy eating behaviors.
Encourage health professionals and staff to become role models for healthy eating behaviors.	Have health professionals and staff model healthy eating behaviors.

TOOL G: STRATEGIES FOR HEALTH PROFESSIONALS TO PROMOTE HEALTHY EATING BEHAVIORS, CONTINUED

STRATEGIES	APPLICATIONS/QUESTIONS
Readiness to Change	
Identify the child's or adolescent's stage of behavior change and readiness to change based on the Stages of Change model (Tool F).	<p>"Do you want to change the way you eat?"</p> <p>"Are you thinking about changing the way you eat?"</p> <p>"Are you ready to change the way you eat?"</p> <p>"Are you changing the way you eat?"</p> <p>"Are you trying to keep eating the way you have been?"</p>
Facilitate behavior change with counseling strategies tailored to the child or adolescent based on the Stages of Change model (Tool F).	<p>Provide a supportive environment, basic information, and assessment.</p> <p>Prioritize behaviors to be changed, set goals, and identify barriers to change.</p> <p>Develop a plan that incorporates incremental steps for making changes, support, and reinforcement.</p>
Action Plans	
Provide counseling for the child or adolescent who is in the early stages of behavior change or who is unwilling to change.	<p>Increase the child's or adolescent's awareness and knowledge of eating behaviors.</p> <p>Encourage the child or adolescent to make behavior changes.</p>
Provide task-oriented counseling for the child or adolescent who is ready to change eating behaviors.	<p>Encourage a few small, concrete changes first, and build on those.</p> <p>Support and follow up with the child or adolescent who has changed behavior.</p>
Identify and prioritize behavior changes to be made.	Suggest changes that will have a measurable impact on the child's or adolescent's most serious nutrition issues.
Set realistic, achievable goals that are supported by the child's or adolescent's family.	<p>"What will you change?"</p> <p>"What goal is realistic right now?"</p> <p>"How and when will you change, and who will help you?"</p>
Identify and address barriers to behavior change; help reduce barriers when possible.	"What could make it hard for you to make this change—money, friends, or family?" "How can you get around this?"
Make sure that the behavior changes are compatible with the child's or adolescent's lifestyle.	Don't expect the child or adolescent to conform to rigid eating behaviors. Keep in mind current behaviors and realistic goals.
Establish incremental steps to help the child or adolescent change eating behaviors.	For example, have the child or adolescent reduce fat consumption by changing the type of milk consumed, from reduced-fat (2%), to low-fat (1%), to fat-free (skim) milk.
Encourage the child or adolescent to commit to behavior changes with contracts.	Discuss non-food rewards (incentives) to help the child or adolescent focus on changing eating behaviors.
Give the child or adolescent responsibility for changing and monitoring eating behaviors.	<p>Stress the importance of planning how the child or adolescent will make and track changes in eating behavior.</p> <p>Make record-keeping simple, and review the plan with the child or adolescent.</p>

TOOL G: STRATEGIES FOR HEALTH PROFESSIONALS TO PROMOTE HEALTHY EATING BEHAVIORS, CONTINUED

STRATEGIES	APPLICATIONS/QUESTIONS
Help the child or adolescent obtain family and peer support.	Discuss how the child or adolescent can encourage parents and peers to help. Meet with parents to clarify goals and action plans; determine how they can help. Provide nutrition education or counseling to parents, as appropriate.
Offer feedback and reinforce successes.	Show interest to encourage continued behavior change.
General Strategies	
Ask the child or adolescent about changes in eating behaviors at every visit.	"How are you doing in changing the way you eat?"
Emphasize to the child or adolescent the consumption of foods rather than nutrients.	For example, say, "drink more milk, and eat more cheese, and yogurt" rather than "you need more calcium."
Build on positive aspects of the child's or adolescent's eating behaviors.	"It's great that you're eating breakfast. Would you be willing to try cereal, fruit, and toast instead of bacon and doughnuts 4 days a week?"
Focus on "how to" instead of "why" information.	Share behaviorally oriented information (eg, what, how much, and when to eat and how to prepare food) rather than focusing on why the information is important.
Provide counseling that integrates realistic behavior change into the child's or adolescent's lifestyle.	"I understand that your friends eat lunch at fast-food restaurants. Would it help you to learn how to make healthier food choices at these restaurants?"
Discuss how to make healthy food choices in a variety of settings.	Talk about how to choose foods in various settings such as fast-food and other restaurants, convenience stores, vending machines, and friends' homes.
Provide the child or adolescent with learning experiences and skills practice.	Practice problem-solving and role-playing (eg, having the child or adolescent ask the food server to hold the mayonnaise).
Introduce the concept of achieving balance and enjoying all foods in moderation.	"Your food record shows that after having pepperoni pizza for lunch yesterday, you ate a lighter dinner. That's a good way to balance your food intake throughout the day."
Make record-keeping easy, and tell the child or adolescent that you do not expect spelling, handwriting, and eating behaviors to be perfect.	"Be as accurate and honest as you can as you record your food intake. This record is a tool to help you think about how you eat."
Make sure that the child or adolescent hears what you are saying.	"What are you planning to work on before your next appointment?"
Make sure that you and the child or adolescent define terms in the same way to avoid confusion.	Discuss the definition of words that may cause confusion, such as "fat," "calories," "meal," and "snack."
When assessing food intake, keep in mind that a child's or adolescent's portion size may not be the same as a standard serving size.	Use food models or household cups and bowls to clarify serving sizes.



TOOL H

Basics for Handling Food Safely¹

Safe food handling, cooking, and storage are essential to prevent food-borne illness. You can't see, smell, or taste harmful bacteria that may cause illness. In every step of food preparation, follow 4 guidelines to keep food safe.

- Clean—Wash hands and surfaces often.
- Separate—Don't cross-contaminate.
- Cook—Cook to proper temperatures.
- Chill—Refrigerate promptly.

SHOPPING

- Buy refrigerated or frozen items after selecting non-perishable food.
- Never buy meat or poultry in packaging that is torn or leaking.
- Never buy food after “sell-by,” “use-by,” or other expiration dates.

STORAGE

- Always refrigerate perishable food within 2 hours (1 hour when the temperature is above 90°F).
- Check the temperatures of your refrigerator and freezer with an appliance thermometer. The refrigerator should be at 40°F or below and the freezer at 0°F or below.
- Cook or freeze fresh poultry, fish, ground meat, and variety meat (eg, calf's tongue) within 2 days; cook or freeze other beef, veal, lamb, or pork within 3 to 5 days.
- Make sure perishable food such as meat and poultry is wrapped securely to maintain quality and to prevent meat juices from coming into contact with other food.
- To maintain quality when freezing meat and poultry in its original package, wrap the package again with foil or plastic wrap that is recommended for the freezer.
- In general, canned high-acid foods such as tomatoes, grapefruit, and pineapple can be stored for 12 to 18 months. Canned low-acid foods such as meat, poultry, fish, and most vegetables can be stored for 2 to 5 years if the can remains in good condition and has been kept in a cool, clean, and dry place. Discard cans that are dented, leaking, bulging, or rusted.

PREPARATION

- Always wash your hands with warm water and soap for 20 seconds before and after handling food.
- Don't cross-contaminate. Keep raw meat, poultry, fish, and their juices away from other food. After cutting raw meat, wash the cutting board, utensils, and countertops with hot, soapy water.
- Sanitize cutting boards, utensils, and countertops with a solution of 1 tablespoon of unscented, liquid chlorine bleach in 1 gallon of water.
- Marinate meat and poultry in a covered dish in the refrigerator.

THAWING

- Refrigerator: The refrigerator allows slow, safe thawing. Make sure thawing meat and poultry juices do not drip onto other food.
- Cold water: For faster thawing, place food in a leak-proof plastic bag and submerge the bag in cold tap water. Change the water every 30 minutes. Cook immediately after thawing.
- Microwave: For fastest thawing, use the microwave. Place food in cookware that is manufactured for use in the microwave and cover with a lid or microwave-safe plastic wrap to hold in moisture and provide safe, even heating. Cook meat, poultry, egg casseroles, and fish immediately after microwave thawing.

COOKING (MINIMAL INTERNAL TEMPERATURE)

- Beef, veal, and lamb steaks; roasts; and chops cooked to 145°F
- All cuts of pork cooked to 160°F
- Ground beef, veal, and lamb cooked to 160°F
- Poultry cooked to 165°F

SERVING

- Hot food should be held at 140°F or warmer.
- Cold food should be held at 40°F or colder.
- At buffets, keep food hot with chafing dishes, slow cookers, and warming trays. Keep food cold by nesting dishes in bowls of ice.
- Perishable food should not be kept at room temperature for more than 2 hours (1 hour when the temperature is above 90°F).

LEFTOVERS

- Discard any perishable food kept at room temperature for more than 2 hours (1 hour if the temperature was above 90°F).
- Place perishable food in shallow containers and immediately put it in the refrigerator or freezer for rapid cooling.
- Use cooked leftovers within 4 days.

REFREEZING

- Meat and poultry defrosted in the refrigerator may be refrozen before or after cooking. For meat thawed by other methods, cook before refreezing.

REFERENCE

1. US Department of Agriculture, Food Safety and Inspection Service. *Basics for Handling Food Safely*. Washington, DC: US Department of Agriculture, Food Safety and Inspection Service; 2006



TOOL I

Tips for Fostering a Positive Body Image Among Children and Adolescents

Tool I: Tips for Fostering a Positive Body Image Among Children and Adolescents

CHILD OR ADOLESCENT	PARENTS	HEALTH PROFESSIONAL
<p>Look in the mirror and focus on your positive features, not your negative ones.</p> <p>Say something nice to your friends about how they look.</p> <p>Think about your positive traits that are not related to appearance.</p> <p>Look at magazines with a critical eye, and find out what photographers and graphic designers do to make models look the way they do.</p> <p>If you are overweight and want to lose weight, be realistic in your expectations, and aim for gradual change.</p> <p>Realize that everyone has a unique size and shape.</p> <p>If you have questions about your size or weight, ask a health professional.</p>	<p>Model healthy eating and physical activity behaviors, and avoid extreme eating and physical activity behaviors.</p> <p>Focus on non–appearance-related traits when discussing yourself and others.</p> <p>Praise your child or adolescent for academic and other successes.</p> <p>Analyze media messages with your child or adolescent.</p> <p>Show that you love your child or adolescent regardless of what he weighs.</p> <p>If your child or adolescent is overweight, don't criticize her appearance—offer support instead.</p> <p>Share with a health professional any concerns you have about your child's or adolescent's eating behaviors or body image.</p>	<p>Discuss changes that occur during adolescence.</p> <p>Assess weight concerns and body image.</p> <p>If a child or adolescent has a distorted body image, explore causes and discuss potential consequences.</p> <p>Discuss how the media negatively affects body image.</p> <p>Discuss normal variation in body sizes and shapes among children and adolescents.</p> <p>Educate parents, physical education instructors, and coaches about realistic and healthy body weights.</p> <p>Emphasize the positive characteristics (related to appearance and not related to appearance) of children and adolescents you see.</p>

TOOL 1: TIPS FOR FOSTERING A POSITIVE BODY IMAGE AMONG CHILDREN AND ADOLESCENTS, CONTINUED

CHILD OR ADOLESCENT	PARENTS	HEALTH PROFESSIONAL
		<p>Take extra time with an overweight child or adolescent to discuss psychosocial concerns and weight control options.</p> <p>Refer children, adolescents, and parents with weight-control issues to a registered dietitian or other health professional.</p>



TOOL J

Nutrition Resources

This tool identifies organizations that may provide additional assistance. General nutrition resources are listed first, followed by resources for specific nutrition issues and concerns.

GENERAL NUTRITION RESOURCES

American Academy of Family Physicians

11400 Tomahawk Creek Parkway
Leawood, KS 66211-2672
Shawnee Mission, KS 66207-1210
Phone: 913/906-6000, 800/274-2237
Web site: <http://www.aafp.org>

American Academy of Pediatrics

141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1019
Phone: 847/434-4000
Web site: <http://www.aap.org>

American College of Obstetricians and Gynecologists

409 12th Street SW
Washington, DC 20090-6920
Phone: 202/638-5577
Web site: <http://www.acog.org>

American Dietetic Association

120 South Riverside Plaza, Suite 2000
Chicago, Illinois 60606-6995
Phone: 800/877-1600
Web site: <http://www.eatright.org>

American Medical Association

515 North State Street
Chicago, IL 60654
Phone: 800/621-8335
Web site: <http://www.ama-assn.org>

American Nurses Association

8515 Georgia Avenue, Suite 400
Silver Spring, MD 20910-3492
Phone: 301/628-5000, 800/274-4262
Web site: <http://www.ana.org>

American Psychological Association

750 First Street NE
Washington, DC 20002-4242
Phone: 202/336-5500, 800/374-2721
Web site: <http://www.apa.org>

American Public Health Association

800 I Street NW
Washington, DC 20001-3710
Phone: 202/777-2742
Web site: <http://www.apha.org>

American School Health Association

Food and Nutrition Council
7263 State Route 43
Kent, OH 44240-0708
Phone: 330/678-1601
Web site: <http://www.ashaweb.org>

Association of State and Territorial Public Health Nutrition Directors

PO Box 1001
Johnstown, PA 15907-1001
Phone: 814/255-2829
Web site: <http://www.astphnd.org>

Center for Science in the Public Interest

1875 Connecticut Avenue NW, Suite 300
Washington, DC 20009-5728
Phone: 202/332-9110
Web site: <http://www.cspinet.org>

Food and Nutrition Board

Institute of Medicine
500 Fifth Street NW
Washington, DC 20001
Phone: 202/334-2352
Web site: <http://www.iom.edu/CMS/3788.aspx>

Food Research and Action Center

1875 Connecticut Avenue NW, Suite 540
 Washington, DC 20009
 Phone: 202/986-2200
 Web site: <http://www.frac.org>

**Health Resources and Services Administration
Information Center**

PO Box 2910
 Merrifield, VA 22116
 Phone: 888/275-4772
 Web site: <http://ask.hrsa.gov>

International Food Information Council

1100 Connecticut Avenue NW, Suite 430
 Washington, DC 20036
 Phone: 202/296-6540
 Web site: <http://www.ific.org>

International Life Sciences Institute

1156 15th Street NW, Suite 200
 Washington, DC 20005-5802
 Phone: 202/659-0074
 Web site: <http://www.ilsa.org>

**National Center for Education in Maternal
and Child Health**

Georgetown University
 2115 Wisconsin Avenue NW, Suite 601
 Washington, DC 20007-2292
 Phone: 202/784-9770
 Web site: <http://www.mchlibrary.info>

National Food Service Management Institute

The University of Mississippi
 6 Jeanette Phillips Drive
 PO Drawer 188
 University, MS 38677-0188
 Phone: 662/915-7658, 800/321-3054
 Web site: <http://www.nfsmi.org>

National WIC Association

2001 S Street NW, Suite 580
 Washington, DC 20009-3355
 Phone: 202/232-5492
 Web site: <http://www.nwica.org>

School Nutrition Association

120 Waterfront Street, Suite 300
 National Harbor, MD 20745
 Phone: 301/686-3100
 Web site: <http://www.asfsa.org>

Society for Nutrition Education

9100 Purdue Road, Suite 200
 Indianapolis, IN 46268
 Phone: 317/328-4627, 800/235-6690
 Web site: <http://www.sne.org>

US DEPARTMENT OF AGRICULTURE**Center for Nutrition Policy and Promotion**

3101 Park Center Drive, 10th Floor
 Alexandria, VA 22302-1594
 Phone: 703/305-7600
 Web site: <http://www.usda.gov/cnpp>

**Expanded Food and Nutrition Education
Program**

1400 Independence Avenue SW, Stop 2201
 Washington, DC 20250-2201
 Phone: 202/720-4423
 Web site: <http://www.crees.usda.gov/nea/food/efnep/efnep.html>

Food and Nutrition Service

3101 Park Center Drive
 Alexandria, VA 22302
 Phone: 703/305-2281
 Web site: <http://www.fns.usda.gov/fns>

National Agricultural Library

Food and Nutrition Information Center
 10301 Baltimore Avenue, Room 105
 Beltsville, MD 20705-2351
 Phone: 301/504-5414
 Web site: <http://fnic.nal.usda.gov>

National Institute of Food and Agriculture

1400 Independence Avenue SW, Stop 2201
 Washington, DC 20250-2201
 Phone: 202/720-4423
 Web site: <http://www.csrees.usda.gov>

US DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

1600 Clifton Road
Atlanta, GA 30333
Phone: 404/498-1515, 800/311-3435
Web site: <http://www.cdc.gov>

Indian Health Service

Office of Clinical and Preventive Services
The Reyes Building
801 Thompson Avenue, Suite 400
Rockville, MD 20852-1627
Phone: 301/443-4464
Web site: <http://www.ihs.gov>

Maternal and Child Health Bureau

5600 Fishers Lane
Parklawn Building, Room 18-05
Rockville, MD 20857
Phone: 301/443-2340
Web site: <http://www.mchb.hrsa.gov>

National Center for Health Statistics

3311 Toledo Road
Hyattsville, MD 20782
Phone: 800/232-4636
Web site: <http://www.cdc.gov/nchs>

National Institutes of Health

Division of Nutrition Research Coordination
6707 Democracy Boulevard, Room 624,
MSC 5461

Bethesda, MD 20892-5461
Phone: 301/594-8822
Web site: <http://dnrc.nih.gov>

Eunice Kennedy Shriver National Institute of
Child Health and Human Development

31 Center Drive
Building 31, Room 2A32, MSC 2425
Bethesda, MD 20892-2425
Phone: 800/370-2943
Web site: <http://www.nichd.nih.gov>

Office of Disease Prevention and Health Promotion

1101 Wootton Parkway, Suite LL100
Rockville, MD 20852
Phone: 240/453-8280
Web site: <http://health.gov>

US Food and Drug Administration

Center for Food Safety and Applied Nutrition
5100 Paint Branch Parkway
College Park, MD 20740-3835
Phone: 888/723-3366
Web site: <http://www.cfsan.fda.gov>

NUTRITION ISSUES AND CONCERNS

BREASTFEEDING

Academy of Breastfeeding Medicine

140 Huguenot Street, Third Floor
New Rochelle, NY 10801
Phone: 914/740-2115, 800/990-4226
Web site: <http://www.bfmed.org>

International Lactation Consultant Association

2501 Aerial Center Parkway, Suite 103
Morrisville, NC 27560
Phone: 919/861-5577, 888/452-2478
Web site: <http://www.ilca.org>

La Leche League International

PO Box 4079
Schaumburg, IL 60168-4079
Phone: 847/519-7730, 800/525-3243
Web site: <http://www.lalecheleague.org>

CHILDREN AND ADOLESCENTS WITH SPECIAL HEALTH CARE NEEDS

American Association on Intellectual and Developmental Disabilities

501 3rd Street NW, Suite 200
Washington, DC 20001
Phone: 202/387-1968, 800/424-3688
Web site: <http://www.aamr.org>

Easter Seals

233 South Wacker Drive, Suite 2400
Chicago, IL 60606
Phone: 312/726-6200, 800/221-6827
Web site: <http://www.easter-seals.org>

Family Voices

2340 Alamo SE, Suite 102
Albuquerque, NM 87106
Phone: 505/872-4774, 888/835-5669
Web site: <http://www.familyvoices.org>

March of Dimes

1275 Mamaroneck Avenue
White Plains, NY 10605
Phone: 914/997-4488
Web site: <http://www.modimes.org>

National Dissemination Center for Children with Disabilities

1825 Connecticut Avenue NW, Suite 700
Washington, DC 20009
Phone: 800/695-0285
Web site: <http://www.nichcy.org>

DIABETES MELLITUS**American Diabetes Association**

1701 North Beauregard Street
Alexandria, VA 22311
Phone: 800/342-2383
Web site: <http://www.diabetes.org>

International Diabetes Center

Park Nicollet Clinic—St Louis Park
3800 Park Nicollet Boulevard
St Louis Park, MN 55416-2699
Phone: 952/993-3393, 888/825-6315
Web site: <http://www.parknicollet.com/diabetes>

National Diabetes Information Clearinghouse

1 Information Way
Bethesda, MD 20892-3560
Phone: 800/860-8747
Web site: <http://diabetes.niddk.nih.gov/about/index.htm>

National Institute of Diabetes and Digestive and Kidney Diseases

31 Center Drive, MSC 2560
Building 31, Room 9A06
Bethesda, MD 20892-2560
Phone: 301/496-3583
Web site: <http://www2.niddk.nih.gov>

EATING DISORDERS**National Eating Disorders Association**

603 Stewart Street, Suite 803
Seattle, WA 98101
Phone: 206/382-3587
Web site: <http://www.nationaleatingdisorders.org>

FOOD ALLERGY**American Academy of Allergy, Asthma & Immunology**

555 East Wells Street, Suite 1100
Milwaukee, WI 53202-3823
Phone: 414/272-6071
Web site: <http://www.aaaai.org>

The Food Allergy & Anaphylaxis Network

11781 Lee Jackson Highway, Suite 160
Fairfax, VA 22033-3309
Phone: 800/929-4040
Web site: <http://www.foodallergy.org>

National Institute of Allergy and Infectious Diseases

National Institutes of Health
6610 Rockledge Drive, MSC 6612
Bethesda, MD 20892-6612
Phone: 301/496-5717, 866/284-4107
Web site: <http://www3.niaid.nih.gov>

HUMAN IMMUNODEFICIENCY VIRUS**Elizabeth Glaser Pediatric AIDS Foundation**

1140 Connecticut Avenue NW, Suite 200
Washington, DC 20036
Phone: 202/296-9165
Web site: <http://www.pedaids.org>

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Centers for Disease Control and Prevention
1600 Clifton Road NE
Atlanta, GA 30333
Phone: 800/232-4636
Web site: <http://www.cdc.gov/nchhstp>

HYPERLIPIDEMIA**American Heart Association**

National Center
7272 Greenville Avenue
Dallas, TX 75231
Phone: 800/242-8721
Web site: <http://www.americanheart.org>

National Heart, Lung, and Blood Institute

National Institutes of Health
31 Center Drive, MSC 2486
Building 31, Rom 5A48
Bethesda, MD 20892
Phone: 301/592-8573
<http://www.nhlbi.nih.gov>

HYPERTENSION**American Society of Hypertension**

148 Madison Avenue, Fifth Floor
New York, NY 10016
Phone: 212/696-9099
Web site: <http://www.ash-us.org>

National Heart, Lung, and Blood Institute

National Institutes of Health
31 Center Drive, MSC 2486
Building 31, Rom 5A48
Bethesda, MD 20892
Phone: 301/592-8573
<http://www.nhlbi.nih.gov>

NUTRITION AND SPORTS**American Alliance for Health, Physical Education, Recreation and Dance**

1900 Association Drive
Reston, VA 20191-1598
Phone: 800/213-7193
Web site: <http://www.aahperd.org>

American College of Sports Medicine

401 West Michigan Street
Indianapolis, IN 46206-3233
Phone: 317/637-9200
Web site: <http://www.acsm.org>

Disabled Sports USA

451 Hungerford Drive, Suite 100
Rockville, MD 20850
Phone: 301/217-0960
Web site: <http://www.dsusa.org>

National Recreation and Park Association

22377 Belmont Ridge Road
Ashburn, VA 20148
Phone: 800/626-6772
Web site: <http://www.nrpa.org>

National Sports Center for the Disabled

PO Box 1290
Winter Park, CO 80482
Phone: 303/316-1540, 970/726-1540
Web site: <http://www.nscd.org>

President's Council on Physical Fitness and Sports

1101 Wootton Parkway, Suite 560
Rockville, MD 20852
Phone: 240/276-9567
Web site: <http://www.fitness.gov>

Special Olympics

1133 19th Street NW
Washington, DC 20036
Phone: 202/628-3630, 800/700-8585
Web site: <http://www.specialolympics.org>

OBESITY**Action for Healthy Kids**

4711 West Golf Road, Suite 625
Skokie, IL 60076
Phone: 800/416-5136
Web site: <http://www.actionforhealthykids.org>

Centers for Disease Control and Prevention

Division of Nutrition, Physical Activity,
and Obesity
1600 Clifton Road
Atlanta, GA 30333
Phone: 800/232-6348
Web site: <http://www.cdc.gov/nccdphp/dnpao>

National Heart, Lung, and Blood Institute

National Institutes of Health
31 Center Drive, MSC 2486
Building 31, Rom 5A48
Bethesda, MD 20892
Phone: 301/592-8573
<http://www.nhlbi.nih.gov>

Weight-control Information Network

1 WIN Way
Bethesda, MD 20892-3665
Phone: 877/946-4627
Fax: 202/828-1028
Web site: <http://win.niddk.nih.gov>

ORAL HEALTH**American Academy of Pediatric Dentistry**

211 East Chicago Avenue, Suite 1700
Chicago, IL 60611-2637
Phone: 312/337-2169
Web site: <http://www.aapd.org>

American Dental Association

211 East Chicago Avenue
Chicago, IL 60611-2678
Phone: 312/440-2500
Web site: <http://www.ada.org>

American Dental Hygienists' Association

444 North Michigan Avenue, Suite 3400
Chicago, IL 60611
Phone: 312/440-8900
Web site: <http://www.adha.org>

Vegetarian Eating Practices

The Vegetarian Resource Group

PO Box 1463

Baltimore, MD 21203

Tel: 410/366-8343

Fax: 410/366-8804

Web site: <http://www.vrg.org>



TOOL K

Federal Nutrition Assistance Programs

FOOD ASSISTANCE AND NUTRITION PROGRAMS	SERVICES AND BENEFITS	WHO QUALIFIES	FUNDING AND ADMINISTRATIVE AGENCIES	SERVICE PROVIDERS
Child and Adult Care Food Program (CACFP)	Reduced-price or free meals and snacks	Children and adolescents up to age 12; children and adolescents up to age 15 from families of migrant workers; children and adolescents up to age 18 who are residents of emergency shelters; and children and adolescents with a disability (as defined by the state) enrolled in an institution, child care facility, or emergency shelter	US Department of Agriculture (USDA) State education agencies	Child care centers, day care homes, at-risk after-school care programs, and emergency shelters
Commodity Supplemental Food Program (CSFP)	Food	Infants and children up to age 6 from families with incomes $\leq 185\%$ of the federal poverty level	USDA State agency (eg, health)	Local public and nonprofit private agencies
Early Head Start and Head Start	Nutrition services and meals and snacks (through the National School Lunch Program and the School Breakfast Program)	Infants and children up to age 5 and their families receiving public assistance or with incomes $< 100\%$ of the federal poverty level; at least 10% of total enrollment available for infants and children with disabilities	Department of Health and Human Services (DHHS) DHHS regional offices	Local public and private nonprofit and for-profit agencies

TOOL K: FEDERAL NUTRITION ASSISTANCE PROGRAMS, CONTINUED

FOOD ASSISTANCE AND NUTRITION PROGRAMS	SERVICES AND BENEFITS	WHO QUALIFIES	FUNDING AND ADMINISTRATIVE AGENCIES	SERVICE PROVIDERS
Emergency Food Assistance Program (TEFAP)	Food	Varies by state	USDA State agency	Local public and nonprofit private agencies (eg, food banks, food pantries, soup kitchens)
Expanded Food and Nutrition Education Program (EFNEP)	Nutrition education	Children and adolescents from families with limited resources	USDA State land grant universities and Cooperative Extension Service offices	Local Cooperative Extension Service offices
Food Distribution Programs on Indian Reservations (FDPIR)	Food	Children and adolescents from families living on Indian reservations, and children and adolescents from Native American families residing in designated areas near reservations and in the state of Oklahoma with a family member who belongs to a federally recognized tribe; eligibility based on income and resource standards	USDA Indian tribal organizations and USDA, Food and Nutrition office	Indian tribes and tribal organizations
National School Lunch Program (NSLP)	Reduced-price or free lunches and afternoon snacks	Children and adolescents attending school: reduced-price lunches and snacks are available if family income is between 130% and 185% of the federal poverty level; free lunches and snacks available if income \leq 130% of federal poverty level	USDA State education agencies	Public and private nonprofit schools and residential child care institutions
Nutrition Assistance Program (NAP) for Puerto Rico	Cash to purchase food	Children and adolescents from families with household resources (aside from income) of \leq \$2,000 (\leq \$3,000 if household has at least one person age \geq 60) living in Puerto Rico	USDA	Puerto Rico

TOOL K: FEDERAL NUTRITION ASSISTANCE PROGRAMS, CONTINUED

FOOD ASSISTANCE AND NUTRITION PROGRAMS	SERVICES AND BENEFITS	WHO QUALIFIES	FUNDING AND ADMINISTRATIVE AGENCIES	SERVICE PROVIDERS
School Breakfast Program	Reduced-price or free breakfasts	Children and adolescents attending school; same eligibility criteria as NSLP	USDA State education agencies	Public and private nonprofit schools and residential child care institutions
Special Milk Program (SMP)	Reduced-price or free milk	Children and adolescents attending child care programs, schools, and summer camps that do not participate in other federal meal-service programs; same eligibility criteria as NSLP	USDA State education agency	Child care programs, schools, and summer camps
Supplemental Nutrition Assistance Program (SNAP)	Benefits to purchase food	Children and adolescents from families with household resources (aside from income) of $\leq \$2,000$ ($\leq \$3,000$ if household has at least one person age ≥ 60)	USDA State agency (eg, welfare, social services, and human services)	Public assistance and social services agencies, cooperative extension nutrition networks, and public health departments
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	Food, vouchers for food, nutrition education, and referral to health and social services	Infants and children up to age 5 at nutrition risk from families with incomes $\leq 185\%$ of federal poverty level	USDA State agency (eg, health)	Health, social services, and community agencies
Summer Food Service Program (SFSP)	Reduced-price or free meals and snacks	Children and adolescents attending a summer activity program; same eligibility criteria as NSLP	USDA State education agency	Public and private nonprofit schools and nonresidential institutions; local, municipal, county governments; and summer camps

SUGGESTED READING

- Boyle MA, Holben DH. *Community Nutrition in Action: An Entrepreneurial Approach*. 5th ed. Pacific Grove, CA: Brook Cole Publishing Company; 2009
- Edelstein S. *Nutrition in Public Health: A Handbook for Developing Programs and Services*. 3rd ed. Sudbury, MA: Jones & Bartlett Publishers; 2010
- US Department of Agriculture, Cooperative State Research, Education, and Extension Service. *Expanded Food and Nutrition Education Program*. USDA Web site. <http://www.csrees.usda.gov/nea/food/efnep/efnep.html>
- US Department of Agriculture, Food and Nutrition Service. *Child & Adult Care Food Program*. USDA Web site. <http://www.fns.usda.gov/cnd/Care/CACFP/aboutcacfp.htm>
- US Department of Agriculture, Food and Nutrition Service. *Commodity Supplemental Food Program* [fact sheet]. 2010. <http://www.fns.usda.gov/fdd/programs/csfp/pfs-csfp.pdf>
- US Department of Agriculture, Food and Nutrition Service. *The Emergency Food Assistance Program* [fact sheet]. 2009. <http://www.fns.usda.gov/fdd/programs/tefap/pfs-tefap.pdf>
- US Department of Agriculture, Food and Nutrition Service. *Food Distribution Program on Indian Reservation*. USDA Web site. <http://www.fns.usda.gov/fdd/programs/fdpi>
- US Department of Agriculture, Food and Nutrition Service. *Supplemental Nutrition Assistance Program: Eligibility*. USDA Web site. http://www.fns.usda.gov/fsp/applicant_recipients/eligibility.htm
- US Department of Agriculture, Food and Nutrition Service. *Supplemental Nutrition Assistance Program: Frequently Asked Questions*. USDA Web site. <http://www.fns.usda.gov/fsp/faqs.htm>
- US Department of Agriculture, Food and Nutrition Service. *National School Lunch Program* [fact sheet]. 2009. <http://www.fns.usda.gov/cnd/Lunch/AboutLunch/NSLPFactSheet.pdf>
- US Department of Agriculture, Food and Nutrition Service. *Nutrition Assistance Block Grants (NABG)*. USDA Web site. http://www.fns.usda.gov/cga/FactSheets/NABGP_Quick_Facts.htm
- US Department of Agriculture, Food and Nutrition Service. *Special Milk Program*. USDA Web site. <http://www.fns.usda.gov/cnd/Milk>
- US Department of Agriculture, Food and Nutrition Service. *Summer Food Service Program*. USDA Web site. <http://www.fns.usda.gov/cnd/Summer>
- US Department of Agriculture, Food and Nutrition Service. *WIC: The Special Supplemental Nutrition Program for Women, Infants and Children* [fact sheet]. 2009. <http://www.fns.usda.gov/wic/WIC-Fact-Sheet.pdf>
- US Department of Health and Human Services, Administration for Children and Families, Office of Head Start. *About Office of Head Start*. HHS Web site. <http://www.acf.hhs.gov/programs/ohs>