



Child Application

**WIC is here to help your child grow & develop normally, eat well and play actively.
The information you share will guide us on how to best serve you & your family.**

Child's Name (First, Middle, Last) _____ **Boy** **Girl** _____ **Child's Birth date** _____ **Today's Date** _____

Your Name _____ Relationship to child _____

Social Security #: _____ **Race: Is this person Hispanic or Latino?** No Yes

You must also select at least one of the following: American Indian/Alaska Native Asian White
 Black/African American Native Hawaiian/Pacific Islander

- Is your child seeing a doctor or dietitian for any health or medical problems?
 No Yes, Describe _____
- In the last 3 months has your child been to the hospital for any reason? No Yes
 Emergency room Hospital overnight Surgery Major Burns (359)
 If any, describe: _____
- Does your child see a dentist for regular check-ups? No Yes Date of last visit _____
- List any medications, vitamins, minerals, or herbal supplements your child is taking?
 Please List _____ (425.7,425.8)
- Was your child ever breastfed? No Yes, still breastfeeding Yes, _____ weeks
- Was your child ever on formula No * Yes, still on formula * Yes – but not now

Please complete if your child is under 2 years old

At birth was your child:

- less than 5#9 oz No Yes, _____ birth weight (153)
- born more than 3 weeks early No Yes, _____ weeks early (142)

My child's immunizations are up to date No Yes

Parents often wonder if their child is eating right. Please tell us about your child's eating.

- Describe your child's appetite. _____
- My child usually eats _____ meals a day and _____ snacks a day.
- Most of the time my child eats well. *(circle a number below)*
 Do not agree 0 1 2 3 4 5 6 7 8 9 10 Strongly agree
- My child is often a picky eater. *(circle a number below)*
 Do not agree 0 1 2 3 4 5 6 7 8 9 10 Strongly agree
- My child eats out: 1 time/week or less 2-4 times/week 5 times/week or more
- My child eats fruits/vegetables: 1 cup/day or less 2 cups/day 3 cups/day or more
- Is your child on a special diet? No Yes, Describe _____ 425.6
- Does your child have trouble eating any foods? No Yes, List: _____ 354, 355
- Does your child have any food allergies? No Yes, List _____ 353
- Does your child crave or eat non-food things, like dirt, clay, soap, ice, or cigarette butts?
 No Yes, Describe: _____ 425.9

*****To Be Completed by Health Care Provider (HCP)*****

Ht _____ (121) Wt _____ (103, 113, 135, 141,151*) Hgb /Hct _____ (201) Medical date _____

ID Verified by: Visual Recognition _____ /Other _____ **HCP verifies applicant lives in Alaska** _____ HCP Name: _____

Certification Date _____ WIC CPA reviews WIC Application WIC CPA's Name: _____

17. Do you run out of money or Food Stamps to buy food? No Yes Sometimes
18. Do you have a working refrigerator? No Yes 411.09

19. **Cooked and pasteurized foods are safe for children. They are heated to kill harmful bacteria. Some raw and un-pasteurized foods are NOT safe for children. Check the box if your child eats.**
- Raw or undercooked meat, poultry, fish, eggs or foods made with raw or lightly cooked eggs
 - Foods with raw or undercooked eggs, like salad dressings, cookie and cake batters, sauces
 - Hot dogs, luncheon meats, fermented and dry sausage, unheated deli-style meat or poultry
 - Refrigerated Smoked Seafood (unless it is in a cooked dish)
 - Soft cheeses made with un-pasteurized milk: Feta, Mexican style (queso blanco fresco), Brie, Blue
 - Raw sprouts (alfalfa, clover and radish)
 - Un-pasteurized milk, fruit or vegetable juice or foods made with Un-pasteurized milk
 - My child does not eat any of these foods

20. What does your child drink? *(check all that apply)* (425.1, 425.2, 425.5)
- | | | | |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Water | <input type="checkbox"/> Skim Milk | <input type="checkbox"/> Dry Milk | <input type="checkbox"/> Pedialyte |
| <input type="checkbox"/> Breast milk | <input type="checkbox"/> Raw milk | <input type="checkbox"/> Soy milk | <input type="checkbox"/> Sweet tea |
| <input type="checkbox"/> Formula | <input type="checkbox"/> Raw juice | <input type="checkbox"/> Rice milk | <input type="checkbox"/> Soda |
| <input type="checkbox"/> Whole Milk | <input type="checkbox"/> Juice | <input type="checkbox"/> Fruit drink <i>(not 100% juice)</i> | |
| <input type="checkbox"/> 2% or 1% Milk | <input type="checkbox"/> Evaporated Milk | <input type="checkbox"/> Tang/Koolaid | |
| <input type="checkbox"/> Other _____ | | | |

21. Circle the form of milk you would like on your WIC checks in your food box:
- | | | | | | |
|--------------|--------------------|------------|-------------------|------------|------------------------|
| Fresh | Fluid (UHT) | Dry | Evaporated | Soy | Lactose Reduced |
|--------------|--------------------|------------|-------------------|------------|------------------------|

22. My child drinks from a: *(check all that apply)* Sippy Cup Cup Baby bottle*
- *If bottle is used, how many bottles are given in 24 hours? _____
- What is in the bottle? List _____
 - When does your child get a bottle? *(check all that apply)* bedtime/naptime
 Mealtime all day other _____
 - If still using a bottle, when would you like to have your child off the bottle? _____
23. Do you have any concerns about your child? *(check all that apply)* no problems (425.4)
- | | | | |
|---|-----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> constipation | <input type="checkbox"/> diarrhea | <input type="checkbox"/> vomiting | <input type="checkbox"/> chewing/swallowing |
| <input type="checkbox"/> choking/gagging <input type="checkbox"/> other _____ | | | |

24. What concerns do you have about your child's growth & development? _____
25. Do you worry anyone you know will hurt your child? No Yes Sometimes

Playtime can help your child be active and gives your family a fun way to get to know each other.

26. What does your child / your family do for fun? _____
27. How active is your child? *(circle a number below)*
- Not very active 0 1 2 3 4 5 very active
28. How much TV does your child watch in a day? *(circle a number below)*
- No TV 0 1 2 3 4 5 more than 5 hours per day
29. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home? No Yes 904
30. On the average, about how many days/week is there smoking anywhere inside your home? _____ 904
31. What is your main concern or goal today – and how can WIC help?
- _____

Thank you!