



Child Application Today's Date \_\_\_\_\_

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 \_\_\_\_\_

Sex \_\_\_\_\_

Social Security Number \_\_\_\_\_

Child's birth date \_\_\_\_\_

Race: Is child Hispanic or Latino? Yes No You must also select one of the following.

Select all that apply:

- checkbox American Indian/Alaskan Native checkbox Asian checkbox White checkbox Black/African American checkbox Native Hawaiian/Pacific Islander

1. Is your child seeing a doctor or dietician for any health or medical problems? checkbox No checkbox Yes, Describe \_\_\_\_\_ (134, 341-349, 351-357, 359-360, 362, 382)

2. In the last 3 months has your child been to the hospital for any reason? checkbox No checkbox Yes (359) checkbox Emergency room checkbox Hospital overnight checkbox Surgery checkbox Major Burns

If any, describe: \_\_\_\_\_

3. Does your child see a dentist for regular check-ups? checkbox No checkbox Yes Date of last visit \_\_\_\_\_

4. List any medications, vitamins, minerals, or herbal supplements your child is taking?

Please List \_\_\_\_\_ (425.7, 425.8)

Parents often wonder if their child is eating right. Tell about your child's eating.

5. My child usually eats \_\_\_\_\_ meals a day and \_\_\_\_\_ snacks a day.

6. Most of the time my child eats well. (circle a number below) Do not agree 0 1 2 3 4 5 Strongly agree

7. My child is often a picky eater. (circle a number below) Do not agree 0 1 2 3 4 5 Strongly agree

8. My child eats fast food: checkbox 1 time/week or less checkbox 2-4 times/week checkbox 5 times/week or more

9. Other than juice, my child eats fruit: checkbox 1 cup/day or less checkbox 2 cups/day checkbox 3 cups/day or more

10. My child eats vegetables: checkbox 1 cup/day or less checkbox 2 cups/day checkbox 3 cups/day or more

11. I think my child should eat more (List foods) \_\_\_\_\_

12. I think my child should eat less (List foods) \_\_\_\_\_

13. Is your child on a special diet? checkbox No checkbox Yes, Describe \_\_\_\_\_ 425.6

14. Does your child have trouble eating any foods? checkbox No checkbox Yes, List: \_\_\_\_\_ 354, 355

15. Does your child have any food allergies? checkbox No checkbox Yes, List \_\_\_\_\_ 353

16. Does your child ever eat non-food things, like dirt, clay, soap, ice, or cigarette butts? checkbox No checkbox Yes, Describe: \_\_\_\_\_ 425.9

17. Do you run out of money or Food Stamps to buy food? checkbox No checkbox Yes checkbox Sometimes

18. Do you worry someone you know will hurt your child? checkbox No checkbox Yes checkbox Sometimes

19. What does your child drink? (check all that apply)

(425.1, 425.2, 425.5)

- Water       Breast milk       formula       Pedialyte
- Whole Milk       2% or 1% Milk       Skim Milk       Raw milk
- Dry Milk       Evaporated Milk       Rice milk       Soy milk
- Juice       Raw juice       Soda       Tang/Kool-aid
- Fruit drink (not 100% juice)       Sweet tea       Capri Sun
- Other milk substitute \_\_\_\_\_       Other \_\_\_\_\_

20. My child drinks from a: (check all that apply)  Sippy Cup       Cup       Baby bottle\*

(419, 425.3)

\*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 \_\_\_\_\_
- When would you like to have your child off the bottle? \_\_\_\_\_

21. Do you have any concerns about your child? (check all that apply)

no problems

(425.4)

- constipation       diarrhea       vomiting       chewing/swallowing
- choking/gagging       other \_\_\_\_\_

22. Do you worry that your child: (check all that apply)

- May be too slender       May be too heavy
- Not eating enough       May be eating too much
- Is not developing well       No worries about child's growth & development
- Other, \_\_\_\_\_

Please complete if your child is under 2 years old

At birth was your child:

- less than 5#8 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

23. What does your child / your family do for fun? \_\_\_\_\_

24. How active is your child? (circle a number below)

Not very active    0    1    2    3    4    5    very active

25. 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

26. What is your main concern today?

\_\_\_\_\_ Thank you!

\*\*\*Office use only\*\*\*

Application reviewed by \_\_\_\_\_

Certification Date \_\_\_\_\_

Ht \_\_\_\_\_ (121)    Wt \_\_\_\_\_ (103, 113, 135, 141,151\*)    Hgb /Hct \_\_\_\_\_ (201)

Staff initials \_\_\_\_\_