



Child Application

Today's Date _____

Boy or Girl _____

Last Name _____ **First Name** _____ **Middle Initial** _____ **Birth Date** _____

Your Name: _____ **Relationship to Child:** _____

If your child is on Medicaid, please provide the Medicaid number or child's SSN _____

Is this child Hispanic or Latino? No Yes

Select at least one of the following: American Indian/Alaska Native Asian White
 Black/African American Native Hawaiian/Pacific Islander

Please answer if your child is under 2

My child's birth weight was less than 5 lbs. 9 oz No Yes 141

My child was born at 37 weeks or less No Yes 142

My child's immunizations are up to date No Yes

WIC helps families with healthy food and nutrition choices.

What concerns, if any, do you have about your child's eating behaviors or growth?

1. What was the child's Birth Weight? _____
Birth Length? _____
2. How many weeks did your pregnancy last? _____
3. At what Birthing Facility was the child born?

4. Please, tell us if your child sees a doctor, dietitian or health care provider for medical or emotional reasons, ex: hypertension, pre-hypertension, diabetes, fetal alcohol syndrome, gastrointestinal disorders or anemia. 151, 201, 341-357, 359, 360, 362, 382
Describe: _____

5. If your child was in the hospital in the last 3 months, please, tell us why. 359

6. Has your child been screened or referred for lead poisoning? No Yes 211

7. When was your child's last dental check-up?
Date _____ 381

8. Does your child have any problems eating any type of food for any reason such as dental problems, food intolerances or others? No Yes 354, 355, 381
Describe: _____

9. List any food allergies your child may have. 353

10. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home No Yes 904

11. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping?
 No Yes 801

12. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals?
 No Yes 801

13. Did a family member have a seasonal farming job with a temporary home in the last 24 months?
 No Yes 802

14. What concerns, if any, do you have about anyone hurting your child? _____
_____ 901

15. Do you have problems taking care of your child?
 No Yes 902

16. Has your child been in foster care or moved to a new foster care home within the last 6 months?
 No Yes 903

17. Circle the type of milk you would like on your WIC checks or in your food box:
Fresh **Fluid (UHT)** **Evaporated**
 Soy **Lactose Reduced** 355 **Dry**

18. What concerns, if any, do you have about having enough food to feed your family?
Comment: _____

To Be Completed by Health Care Provider (HCP)

Medical date _____ Current Wt _____ (103, 113, 134, 135) Ht _____ (121) Hgb /Hct _____ (201)
Name of HCP verifying applicant lives in Alaska _____ **ID Verified by:** Visual Recognition ___/Other ___ WIC
Name of CPA reviewing WIC application _____ Certification Date _____



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Parents often wonder if their child is eating right.

19. On a scale of 0 to 10, how well do think your child is eating? (Circle a number)

Not Well **0 1 2 3 4 5 6 7 8 9 10** Very Well

He/she usually eats ___meals /day and ___snacks/day.

He/she usually eats fruits/vegetables (check amount)

- 1 cup/day or less of fruits/vegetables
- 2 cups/day or less of fruits/vegetables
- 3 cups/day or more of fruits/vegetables

20. My child eats: 425.04, 428

- Liquid Foods Finger Foods
- Table Foods Mashed, Pureed/ Baby Foods

21. Does your child eat meals with the family?

Comment: _____

22. Is your child is on a special diet? No Yes 425.06

Describe _____

23. My child drinks from:(check all that apply) 425.03

- Sippy Cup Cup Bottle

If your child drinks from a bottle, please tell us:

- Number of bottles in 24 hours? _____
- What is in the bottle? _____

24. When does your child get a bottle? 425.03

- Bedtime/Naptime Mealtime
- All day Other _____

25. When do you want your child to only use a cup?

26. **Check the box if you have any of the following concerns about your child:** 342

- Constipation Diarrhea
- Vomiting Chewing/Swallowing
- Choking/Gagging Other _____

27. Does your child crave or eats non-food things like dirt, clay, soap, ice, cigarette butts, ashes, carpet fibers, paper, dust, foam, rubber, paint chips, soil, starch (laundry or cornstarch) or other?

- No Yes 425.09

28. I am breastfeeding my child. No Yes

29. If Breastfed, what date did breastfeeding begin?

On what date did breastfeeding end? _____

30. What was the reason that Breastfeeding was stopped?

31. If your child used(s) formula, at what age did you first offer formula? ___ weeks or ___months old

32. List any medication, vitamin, mineral or herbal supplement your child takes. 357, 425.07, 425.08,

33. **Check the box and circle the foods your child eats.**

- Raw or undercooked meat, poultry, fish, eggs
- Foods with raw or undercooked eggs, like salad dressings, cookie and cake batters, sauces
- Unheated hot dogs, luncheon meats, fermented and dry sausage, deli-style meat or poultry
- Refrigerated Smoked Seafood (unless it is cooked)
- 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 425.05

34. **Check if your child drinks regularly** 425.01, 425.02

- Water Skim Milk Dry Milk
- Pedialyte Breast milk Raw milk
- Soy milk Sweet tea Formula
- Raw juice Rice milk Pop/Soda
- Whole Milk 100% Pasteurized Juice
- Fruit drink (*not 100% juice*) Sport Drinks
- 2% or 1% Milk Evaporated Milk
- Tang/Kool-Aid Cereal/Solids foods in bottle
- Coffee/tea Other _____

35. In a typical day, how much time does your child watch TV, play video and/or play computer games?

- Less than 1 hour 1-2 hours
- More than 2 hours

36. What does your family do for fun?

37. **For Dads** - please tell us your weight _____ and height _____.

38. **How can WIC help your family today?**
