Child Application

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

Today's Date _____

1. Child's Name (First, Middle, Last)	2. Child's Birth Date ☐ Boy ☐ Girl
3. Your Name (First, Middle, Last)	4. Relationship to Child

5. If receiving Medicaid, please provide Medicaid number:

6. Is this child Hispanic or Latino? ☐ Yes ☐ No

7. Race (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Current History

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

9. What was the child's Birth Weight? Birth Length?

10. At what Birthing Facility was the child born?

11. How many weeks did your pregnancy last?

12. Please Answer if your child is under 2:

Child's birth weight was less than 5 lbs. 9 oz ☐ Yes ☐ No 141

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

My child's immunizations are up to date ☐ Yes ☐ No

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

☐ Chewing/Swallowing ☐ Choking/Gagging ☐ Constipation ☐ Diarrhea ☐ Vomiting ☐ Other

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

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

Describe:

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

Eating & Feeding

17. What concerns, if any, do you have about having enough food to feed your family?

18. I am breastfeeding my child. ☐ Yes ☐ No

19. If breastfed, what date did it begin? When did breastfeeding end?

20. What was the reason that breastfeeding was stopped?

21. If your child used(s) formula, at what age (weeks or months) did you first offer?

22. On a scale of 0 to 10,
How well do you think you think your child is eating? Not Well ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Well

a. He/she usually eats_____ meals/day and _____ snacks/day.

b. He/she usually eat fruits: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more

c. He/she usually eat vegetables: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more

23. My child eats: ☐ Liquid Foods ☐ Finger Foods ☐ Table Foods ☐ Mashed, Pureed / Baby Foods 425.04 428

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_____

24. Check the box if your child eats any these foods. 425.05

- ☐ **Raw sprouts:** alfalfa, clover and radish
- ☐ **Raw or undercooked:** meat, chicken, turkey, fish, eggs
- ☐ **Uncooked** refrigerated smoked seafood
- ☐ **Unheated meats:** lunch meats, deli-style meat or chicken, fermented and dry sausage, raw hot dogs
- ☐ **Food with raw or undercooked eggs:** salad dressing, cookie and cake batter, sauces
- ☐ **Soft cheese made with unpasteurized milk:** feta, mexican-style (queso blanco fresco), brie, blue
- ☐ **Unpasteurized** milk or foods made with unpasteurized milk
- ☐ **Unpasteurized** fruit or vegetable juice

25. My child drinks from (Check all that apply): ☐ Sippy Cup ☐ Cup ☐ Baby Bottle 425.03

a. If your child drinks from a baby bottle, how many in 24 hours? _____

b. What's in the baby bottle?

26. When does your child get a baby bottle? ☐ Bedtime/Naptime ☐ Mealtime ☐ All day ☐ Other: 425.03

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

28. Check if your child drinks regularly 425.01 425.02

☐ Water	☐ Dry milk	☐ Whole milk	☐ Sweet tea	☐ 100% Pasteurized juice	☐ Cereal/Solid foods in a baby bottle
☐ Pedialyte	☐ Raw milk	☐ 1% or 2% milk	☐ Coffee/tea	☐ Fruit drink (not 100% juice)	
☐ Soy milk	☐ Breastmilk	☐ Evaporated milk	☐ Tang/Kool-aid	☐ Raw juice	☐ Other _____
☐ Skim milk	☐ Rice milk	☐ Formula	☐ Pop/Soda	☐ Sports Drinks	

29. Check if your child craves or eats: 425.09

☐ Ashes	☐ Carpet Fibers	☐ Clay	☐ Soil
☐ Baking Soda	☐ Chalk	☐ Dust	☐ Starch (laundry or corn starch
☐ Burnt Matches	☐ Cigarettes	☐ Paint Chips	☐ Large quantities of ice and/or freezer frost

30. Does your child eat meals with the family?

31. Is your child on a special diet? 425.06

32. Does your child have any problems eating any type of food for any reason such as dental problems, food intolerances, or others? 354 355 381

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

Additional

34. Has your child been screened or referred for lead poisoning?	☐ Yes	☐ No	211
35. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home?	☐ Yes	☐ No	904
36. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping?	☐ Yes	☐ No	801
37. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals?	☐ Yes	☐ No	801
38. Did a family member have a seasonal farming job with a temporary home in the last 24 months?	☐ Yes	☐ No	802
39. Do you have any concerns about anyone hurting your child?	☐ Yes	☐ No	901
40. Has your child been in foster care or moved to a new foster home within the last 6 months?	☐ Yes	☐ No	

41. What type of milk you would like with your WIC benefits?

☐ Fresh/Refrigerated ☐ Boxed (UHT) ☐ Soy ☐ Dry ☐ Evaporated ☐ Lactose Reduced 355

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

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

43. Do you have problems taking care of your child? 902

44. Write the date of you last child's last dental check-up: (Month, Year) 381

45. For dads, please tell us your weight: height:

46. What does your family do for fun?

47. How can WIC help your family today?

Thank You!

Revised: 5/24/19