



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	<input type="checkbox"/> Boy <input type="checkbox"/> 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's immunizations are up to date Yes No
My child was born at 37 weeks or less Yes No ¹⁴²

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

Describe: 360,362
382

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, 0 1 2 3 4 5 6 7 8 9 10 Very Well
How well do you think you think your child is eating? Not 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

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

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

29. Check if your child craves or eats: 425.09

<input type="checkbox"/> Ashes	<input type="checkbox"/> Carpet Fibers	<input type="checkbox"/> Clay	<input type="checkbox"/> Soil
<input type="checkbox"/> Baking Soda	<input type="checkbox"/> Chalk	<input type="checkbox"/> Dust	<input type="checkbox"/> Starch (laundry or corn starch)
<input type="checkbox"/> Burnt Matches	<input type="checkbox"/> Cigarettes	<input type="checkbox"/> Paint Chips	<input type="checkbox"/> 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? _____