



Infant Application

Today's Date _____

	<input type="checkbox"/> Boy or <input type="checkbox"/> Girl		_____ lbs _____ oz _____ in"
Last Name	First Name	Middle Initial	Birth Date Weight Length
Your Name: _____		Relationship to Child: _____	
If Infant is on Medicaid, please provide the Medicaid number or Infant's SSN: _____			
Is this baby Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Select at least one of the following:			
<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Asian <input type="checkbox"/> White	
<input type="checkbox"/> Black/African American		<input type="checkbox"/> Native Hawaiian/Pacific Islander	
My baby's birth weight was less than 5 lbs. 9 oz		<input type="checkbox"/> No <input type="checkbox"/> Yes	141
My baby was born at 37 weeks or less		<input type="checkbox"/> No <input type="checkbox"/> Yes	142 How many weeks did your pregnancy last? _____
My baby weighed more than 9 pounds at birth		<input type="checkbox"/> No <input type="checkbox"/> Yes	153
My baby's immunizations are up to date		<input type="checkbox"/> No <input type="checkbox"/> Yes	

WIC helps families with healthy food and nutrition choices.

What concerns, if any, do you have about what, how or how much your baby eats?

342, 411.04

1. At what Birthing Facility was the Infant born? _____

2. Please, tell us if your baby sees a doctor, dietitian or health care provider for medical reasons, ex: hypertension, pre-hypertension, diabetes, fetal alcohol syndrome, small for gestational age, gastrointestinal disorders or anemia. **151, 152, 201, 341-357, 359, 360, 362, 382**

Describe: _____

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

4. Has your baby been screened or referred for lead poisoning? No Yes **211**

5. Please, describe any teething problems your baby may be having. _____ **381**

6. Does your baby have any food intolerances or food allergies? No Yes **353, 354, 355**

Describe: _____

7. Is your baby on a special diet? No Yes **411.8**

8. What vitamin, mineral or herbal supplement do you give your baby? _____
If not daily, how often? _____ **411.10, 411.11**

9. List any medication your baby may be taking. **357**

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 baby? _____

_____ **901**

15. Do you have problems taking care of your baby?

No Yes **703,**

902

16. Has your baby been in foster care or moved to a new foster care home within the last 6 months?

No Yes **903**

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

Comment: _____

18. **How are you feeding your baby?**

Breastmilk Breastmilk + Formula Formula Only

If breastfeeding

19. **On what date did breastfeeding begin?** _____

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** _____



Infant Application

20. On a scale of 0 to 10, how is breastfeeding going?

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

- I breastfeed _____ times in 24 hours. **411.7, 603, 702**
- Each feeding lasts _____ minutes. **603, 702**
- My baby has ____ (#) stool diapers a day. **411.7**
- My baby has ____ (#) wet diapers a day. **411.7**

21. Are you breastfeeding another child? No Yes

22. How do you store breastmilk? (i.e., freeze, refrigerate, store on counter, in cabinet, etc.)

_____ **411.9**

23. What do you usually do, if there is leftover breastmilk or formula in the bottle after a feeding? **411.9**

- Throw it out Put in refrigerator
 Leave near baby

If Formula Feeding

24. If you ever breastfed, on what date did breastfeeding end?

25. What was the reason that breastfeeding was stopped?

26. At what age did you start your baby on formula?

- I started my baby on baby formula at the age of _____ days or _____ weeks.

701

On a scale of 0 to 10, how is formula feeding going?

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

27. What formula are you feeding your baby?

28. How often do you feed your baby formula?

29. How much formula does your baby eat at a feeding?

30. How do you prepare your baby's formula? **411.5, 411.6**

- Powdered formula**
I add ____ scoops of powder to ____ ounces water
- Concentrated formula**
I add ____ ounces concentrate to ____ ounces water
- Ready-to-feed formula**
Do you add water? No Yes _____ oz

31. Does your baby drink juice, sweetened drinks, soda, sweet tea, Tang/Koolaid or Hi-C in a bottle or a cup?

- Yes No Sometimes **411.2,**

411.3

32. Do you add sugar, honey or syrup to your baby's pacifier or foods?

- Yes No Sometimes **411.3**

If yes, tell us more about the reasons:

33. How old was your baby the first time he or she drank liquids other than breastmilk or formula?

411.1

My baby was _____ months.

List what he or she drank: _____

34. How old was your baby the first time he or she ate food such as cereal, baby food, or any other food?

My baby was _____ months. **411.3**

List what he or she ate: _____

35. Is your baby held when bottle fed? **381, 411.2**

- Never Rarely Sometimes Always

36. Where else do you give your baby a bottle?

- Crib/Bed Car Seat High-chair Stroller
 Other _____ **411.2**

37. How do you feed your baby solid foods? **411.2, 411.4**

- No solid foods, only breastmilk/formula
 by Spoon In Baby Bottle by Infant Feeder
 Baby foods Finger foods Other _____

38. Check the foods your baby eats? **411.4, 411.5, 411.8**

- No solid foods, only breastmilk/formula
 Infant Cereal Infant Cereal in the bottle
 Homemade baby food Crackers
 Chopped fruits/vegetables Bread
 Strained or mashed vegetables or fruits
 Strained meat/egg yolk/yogurt/cottage cheese/tuna
 Cooked soft pieces of beans/chicken/turkey/beef/pork
 Raw or undercooked meat, poultry, fish, eggs
 Unheated hot dogs/deli meat or poultry
 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

39. How do you know your baby is done eating? **411.4**

- Turns head away Won't open his/her mouth
 Eats all food Bottle is empty Spits out food

40. What does your family do for fun?

41. **For Dads** - please tell us what your weight _____ and height _____ are.

42. How can WIC help your family today?
