



Infant 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 baby is on Medicaid, please provide Medicaid number:

6. Is this baby 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 what, how or how much your baby eats? 342
411.04

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

10. At what Birthing Facility was the child born? How many weeks did your pregnancy last?

11. Are you breastfeeding another child? ☐ Yes ☐ No

12. Please answer about your baby:

My baby's birth weight was less than 5 lbs. 9 oz ☐ Yes ☐ No ¹⁴¹ My baby weighed more than 9 pounds at birth ☐ Yes ☐ No ¹⁵³

My baby was born at 37 weeks or less ☐ Yes ☐ No ¹⁴² My baby's immunizations are up to date ☐ Yes ☐ No

13. List any medication your baby may be taking: 357

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

Describe: 359,360
362,382

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

Eating & Feeding

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

17. How are you feeding your baby? ☐ Breastmilk ☐ Breastmilk + Formula ☐ Formula Only

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

19. What was the reason that breastfeeding was stopped?

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

a. I breastfeed _____ times in 24 hours and each feeding lasts _____ minutes. 411.7
603

b. My baby has _____ (#) stools a day and _____ (#) wet diapers a day. 703
411.7

21. How do you store breastmilk? (i.e. freeze, refrigerate, store on counter, in cabinet, etc.) 411.9

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

☐ Throw it out ☐ Put it in the refrigerator ☐ Leave near baby

23. At what age did you start your baby on formula? ⁷⁰¹ What formula are you feeding your baby?

24. On a scale of 0 to 10, ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
How well do you think formula feeding is going? Not Well 0 1 2 3 4 5 6 7 8 9 10 Very Well

25. How often do you feed your baby formula?

26. How much formula does your baby eat at feeding?

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 _____

27. How do you prepare your baby's formula?	411.5 411.6
<input type="checkbox"/> Powdered formula I add _____ scoops of powder to _____ ounces of water	
<input type="checkbox"/> Concentrated formula I add _____ ounces of formula to _____ ounces of water	
<input type="checkbox"/> Ready-to-feed formula Do you add water? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many ounces of water? _____	
28. Does your baby drink juice, sweetened drinks, soda, sweet tea, Tang/Koolaid or Hi-C in a bottle or cup?	412.2 411.3
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes	
29. Do you add sugar, honey or syrup to your baby's pacifier or foods?	411.3
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes If yes, tell us more about the reasons:	
30. How old was your baby the first time he or she drank liquids other than breastmilk or formula? List what he or she drank:	411.1
31. How old was your baby the first time he or she ate food such as cereal, baby food, or any other food? List what he or she ate:	411.3
32. Is your baby held when bottle fed?	381 411.2
<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Always	
33. Where else do you give your baby a bottle?	411.2
<input type="checkbox"/> Crib/Bed <input type="checkbox"/> Car Seat <input type="checkbox"/> High-chair <input type="checkbox"/> Stroller <input type="checkbox"/> Other _____	
34. How do you feed your baby solid food?	411.2 411.4
<input type="checkbox"/> No solid foods, only breastmilk/formula <input type="checkbox"/> By Spoon <input type="checkbox"/> In Baby Bottle	
<input type="checkbox"/> By Infant Feeder <input type="checkbox"/> Baby Foods <input type="checkbox"/> Finger Foods <input type="checkbox"/> Other _____	
35. Check the box if your baby eats any these foods.	411.4 411.5 411.8
<input type="checkbox"/> Raw sprouts: alfalfa, clover and radish	<input type="checkbox"/> Food with raw or undercooked eggs: salad dressing, cookie and cake batter, sauces
<input type="checkbox"/> Raw or undercooked: meat, chicken, turkey, fish, eggs	<input type="checkbox"/> Soft cheese made with unpasteurized milk: feta, mexican-style (queso blanco fresco), brie, blue
<input type="checkbox"/> Uncooked refrigerated smoked seafood	<input type="checkbox"/> Unpasteurized milk or foods made with unpasteurized milk
<input type="checkbox"/> Unheated meats: lunch meats, deli-style meat or chicken, fermented and dry sausage, raw hot dogs	<input type="checkbox"/> Unpasteurized fruit or vegetable juice
<input type="checkbox"/> Strained: meat, egg yolk, yogurt, cottage cheese, tuna	<input type="checkbox"/> Cooked soft pieces of: beans, chicken, turkey, beef, pork
<input type="checkbox"/> Strained or mashed: vegetables or fruits	<input type="checkbox"/> No solid foods only breastmilk/formula
<input type="checkbox"/> Chopped fruits/vegetables or fruits	<input type="checkbox"/> Infant Cereal in the bottle
<input type="checkbox"/> Homemade baby food	<input type="checkbox"/> Infant Cereal
<input type="checkbox"/> Bread	<input type="checkbox"/> Crackers
36. How do you know your baby is done eating? (Check all that apply)	411.4
<input type="checkbox"/> Turns head away <input type="checkbox"/> Won't open his/her mouth <input type="checkbox"/> Eats all food <input type="checkbox"/> Bottle is empty <input type="checkbox"/> Spits out food	
37. Please describe any teething problems your baby maybe having.	
38. Please describe any food intolerances or food allergies your baby may have.	

Additional

39. Has your baby been screened or referred for lead poisoning?	<input type="checkbox"/> Yes <input type="checkbox"/> No	211
40. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	904
41. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No	801
42. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals?	<input type="checkbox"/> Yes <input type="checkbox"/> No	801
43. Did a family member have a seasonal farming job with a temporary home in the last 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	802
44. Do you have any concerns about anyone hurting your baby?	<input type="checkbox"/> Yes <input type="checkbox"/> No	901
45. Has your child been in foster care or moved to a new foster home within the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	903
46. Do you have any problems taking care of you baby?		
47. For dads, please tell us your weight:	height:	
48. What does your family do for fun?		
49. How can WIC help your family today?		