

**State of Connecticut WIC Program-DEPARTMENT OF PUBLIC HEALTH**  
**CERTIFICATION/MEDICAL REFERRAL FORM - INFANTS AND CHILDREN**

Participant ID #: \_\_\_\_\_ Family ID #: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth (DOB): \_\_\_/\_\_\_/\_\_\_ Sex: M / F

Parent/Guardian: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

<b>DATE COLLECTED:</b>	<b>DATE COLLECTED:</b>	<b>FOR INFANTS AND CHILDREN &lt; 2:</b>
<b>Weight:</b>	<b>Hemoglobin:</b>	<b>Birth Weight:</b>
<b>Length or Height:</b>	<b>Hematocrit:</b>	<b>Birth Length:</b>
<b>Body Mass Index (BMI):</b>	<b>Lead test done? Y or N</b>	<b>Birth Head Circ. (optional):</b>
<b>Head Circ. (optional):</b>	<b>Date collected:</b>	<b>Result:</b>
<b>Immunizations Up-to-date? Y N</b>		
<b>Medications/Medical Problems/Concerns:</b>		

**ANTHROPOMETRIC**

**0-23 months (Based on 2006 WHO Growth Standards)**

- 1a.  Underweight ( $\leq 2.3^{rd}$  percentile wt/length)
- 1b.  At Risk of Underweight ( $>2.3^{rd}$  percentile and  $\leq 5^{th}$  wt/length)
- 2.  High Weight for Length ( $\geq 97.7^{th}$  percentile wt/length)
- 2b.  At Risk of Overweight- Parent with BMI  $\geq 30$
- 3a.  Short Stature ( $\leq 2.3^{rd}$  percentile length/age)
- 3b.  At Risk for Short Stature ( $> 2.3^{rd}$  &  $\leq 5^{th}$  percentile length/age)
- 4.  Failure to thrive
- 5.  Inadequate growth
- 6.  LBW (birth weight  $< 5.5$  pounds or  $< 2500$  grams)
- 7.  Prematurity ( $< 37$  weeks gestation) # weeks gestation \_\_\_\_\_
- 8a.  Small for gestational age (based on medical diagnosis)
- 8b.  Large for gestational age ( $\geq 9$  lbs) (up to 12 months)
- 9.  Head circumference  $\leq 2.3^{rd}$  percentile (up to 24 months)

**2-5 years (Based on 2000 CDC age/gender specific growth charts)**

- 1a.  Underweight ( $\leq 5^{th}$  percentile BMI-for-age)
- 1b.  At Risk of Underweight ( $>5^{th}$  and  $\leq 10^{th}$  percentile BMI-for-age)
- 2a.  Obese ( $\geq 95^{th}$  percentile BMI-for-age)
- 2b.  Overweight ( $\geq 85^{th}$  or  $<95^{th}$  percentile BMI-for-age)
- 2b.  At Risk of Overweight- Parent with BMI  $\geq 30$
- 3a.  Short Stature ( $\leq 5^{th}$  percentile height/age)
- 3b.  At Risk for Short Stature ( $>5^{th}$  and  $\leq 10^{th}$  percentile ht/age)
- 4.  Failure to thrive
- 5.  Inadequate growth

**Weight, length/height measurements must be within 60 days of the WIC certification**

**BIOCHEMICAL (1998 CDC Standards)**

- 10.  Anemia **6-23 Mos:** Hgb  $< 11$  g/dl, Hct  $< 32.9\%$ ;  
**2-5 yrs:** Hgb  $< 11.1$  g/dl, Hct  $< 33\%$

- 11.  Elevated blood lead level ( $\geq 5$ ug/dl in last 12 months)

**CLINICAL/ HEALTH/ MEDICAL**

- 12.  Nutrient deficiency disease. Specify \_\_\_\_\_
- 13.  Gastrointestinal disorder. Specify \_\_\_\_\_
- 14.  Nutritionally significant genetic or congenital disorder.  
Specify \_\_\_\_\_
- 15.  Nutrition related infectious disease. Specify \_\_\_\_\_
- 16.  Nutrition related non-infectious chronic disease.  
Specify \_\_\_\_\_
- 17.  Food allergy. Specify \_\_\_\_\_
- 18.  Other nutrition related medical conditions.  
Specify \_\_\_\_\_

- 19.  Oral health conditions. Specify \_\_\_\_\_
- 20.  Fetal Alcohol Syndrome
- 21.  Infant born of a woman with mental retardation
- 22.  Infant born of a woman who abused alcohol or drugs during most recent pregnancy
- 23.  Breastfeeding complications or potential complications.  
Specify \_\_\_\_\_
- 24.  Breastfeeding infant of woman at nutritional risk  
 non-dietary;  dietary

**DIETARY** (Document in SWIS or on WIC Nutrition Questionnaire and Assessment form)

- 25.  Specify code(s) \_\_\_\_\_  
 Improper use of bottle/cup or (pacifier-Child only)  Potentially harmful microorganisms/toxins  Feeding sugar containing fluids

**OTHER NUTRITIONAL RISKS**

- 26.  Infant (0-6 months) of a mother enrolled in WIC or of a woman who would have been WIC eligible during pregnancy
- 27.  Possible regression in nutritional status if removed from the Program  non-dietary;  dietary
- 28.  Homelessness or migrancy
- 29.  Entering or moving within the foster care system during the previous 6 months
- 30.  Other risks. Specify \_\_\_\_\_

Health Care Provider Signature and Title: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

WIC OFFICE USE: Physical Presence:  Yes  No Date: \_\_\_\_\_ Waiver Code: MC/ ND/ OHC/ WPC  
 Priority group: 1 2 3 4 5 6 Signature/Initials of WIC CPA \_\_\_\_\_ WIC Certification Date: \_\_\_\_\_  Mid-cert

**Applicant/Participant Authorization/Autorización del solicitante/participante:**

I, Yo, \_\_\_\_\_ give permission to/ doy mi permiso a:  
(Print Name/ Nombre en letra de imprenta)

Date/ Fecha \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_  
(Health Care Provider or Organization/ Proveedor de atención de la salud u organización)

Date/ Fecha \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_  
(Health Care Provider or Organization/ Proveedor de atención de la salud u organización)

Date/ Fecha \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_  
(Health Care Provider or Organization/ Proveedor de atención de la salud u organización)

to release my child's health information, listed on the other side of this WIC certification form to the WIC Program, for WIC staff to determine if my child qualifies for the WIC Program and to coordinate WIC nutrition services for my child. I also agree WIC staff may talk with my child's health care provider and/or the organization listed above about any medical/behavioral concerns that may affect my child's overall health in order to better coordinate my child's care.

para divulgar la información de mi hijo —la cual se encuentra en el reverso de este formulario de certificación del Programa WIC, para que el personal del Programa WIC determine si mi hijo es elegible para el WIC y para coordinar los servicios de nutrición que el WIC brindará a mi hijo. También acepto que es posible que el personal del WIC se comunique con el proveedor de atención de la salud de mi hijo o la organización indicada anteriormente sobre toda inquietud médica o del comportamiento que pueda afectar la salud general del mi hijo para coordinar mejor la atención de mi hijo.

- I understand that if my child's well exam is not timed with my WIC certification visit; WIC staff will make efforts to obtain the health information needed to complete the WIC certification visit (e.g. height/length or weight).
- Comprendo que si el examen del niño sano de mi hijo no está coordinado con la visita de certificación del Programa WIC, el personal del WIC se esforzará por obtener la información médica necesaria para completar dicha visita ( altura/largo y peso).
- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to my health care provider or organization listed above and send it or take it to where I am now giving permission. Let WIC staff know if you cancel permission with your provider.  Permission cancelled **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_
- Comprendo que puedo cambiar de idea y cancelar esta autorización en cualquier momento. Para hacerlo, debo escribir una carta a mi proveedor de atención de la salud o la organización indicada anteriormente y enviarla o llevarla al lugar donde ahora estoy dando mi permiso.  El permiso cancelado **Fecha** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Authorized Signature/Firma del representante autorizado:** \_\_\_\_\_

**Relationship to Participant/Relación con el participante:** \_\_\_\_\_ **Date/ Fecha** \_\_\_\_/\_\_\_\_/\_\_\_\_

**This permission is good for one (1) year from the date of the authorized signature above.**  
**Este permiso es válido durante un año a partir de la fecha de la firma del representante autorizado precedente.**

**If the information has already been given out, I understand it is too late for me to change my mind and cancel the permission.**  
**Si mi información ya ha sido proporcionada, comprendo que es demasiado tarde para que cambie de opinión y cancele el permiso.**

WIC staff follows Federal law to protect WIC participant privacy (confidentiality) and cannot re-disclose (share) WIC applicant or participant information except with written consent or as required by law.

El personal del WIC sigue las leyes federales para proteger la privacidad (confidencialidad) de los participantes del WIC y no puede revelar (compartir) la información del solicitante o participante del WIC, a menos que cuente con un consentimiento por escrito o según lo requiera la ley.

**Declined/Rechazado** **Date/ Fecha** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Would you like to register to vote today? /¿Le gustaría registrarse para votar hoy?** Yes/ Sí No/ No **Initials/Iniciales:**

**WIC OFFICE USE ONLY:**

\_\_\_\_\_  
**Signature/Initials of WIC Staff verifying income, residency and identity** **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**USDA is an equal opportunity provider and employer. El USDA es un proveedor y empleador que ofrece igualdad de oportunidades.**

## Guidelines for Use

### Participant Information and Health Data and Nutrition Risk sections:

- Participant and/or Family ID #: To be completed by WIC Program staff.
- All other **participant information** fields to be completed by WIC staff- most likely a Program Assistant or health care provider's (HCP) office staff- including Participant Name, Date of Birth, Sex, Parent's/Guardian's Name, Address, Phone # and Health Insurance Plan.

**Participant Health Data fields** to be completed by the HCP and/or the WIC Nutrition staff i.e. Competent Professional Authority (CPA). For infants and children: weight, length/height, BMI, hematological data, immunizations and medications/medical conditions. Note: Weight, length/height measurements must be within 60 days of WIC certification appointment.

Hemoglobin or hematocrit results must be within the following timeframes for infant and child participants. Timing of bloodwork is dependent on the initial infant blood test: 9-12 months, 15-18 months, 2 years, 3 years and 4 years. If results are abnormal, a repeat test is required within 6 months as indicated by Federal WIC Regulations, which follow the CDC's [\*Recommendations to Prevent and Control Iron Deficiency in the United States\*](#). MMWR 1998; 47 (No. RR-3) p. 5.

HCP or WIC CPA to check all applicable nutrition risk factors including anthropometric, biochemical, clinical/health/medical/dietary or other based on medical examination or complete nutrition assessment. Specify condition when indicated. Note: If the WIC CPA has questions or concerns regarding data entered by the HCP he/she should follow up as appropriate for clarification.

**Health Care Provider Signature and Title is required.** The HCP must complete the date and address (location) of practice, clinic or office. By signing this form the HCP verifies he/she has seen and evaluated the patient. In cases where this form is being completed at a time other than certification, e.g. for coordination of health care purposes, a signature is also required for that health care provider as verification.

**Shaded Gray area:** To be completed by WIC CPA. Determine physical presence, and record date. If participant is physically present in office, check "Yes". If participant is not physically in the office, but meets one of the waiver criteria check "No" and then circle the appropriate waiver code. Note: A waiver for physical presence cannot be used for consecutive certifications. Currently, SWIS determines the participant's priority group. It is an option for the WIC CPA to circle the SWIS indicated priority group on the hard copy certification form. Local agencies can choose to use this field for internal quality assurance processes. WIC CPA Signature and WIC Certification date is required to certify participant is **WIC eligible**. If the form is being used for a mid-certification, check the appropriate box.

### Applicant/Participant Authorization Section:

This section must be completed by all applicants and participants, even if the front of the form is filled out prior to the participant visiting the WIC local agency. If applicant or participant declines to allow share anthropometric information with WIC from the health care provider or organization listed, check the box marked, declined. WIC staff must take anthropometric measurements in the WIC office. See WIC 200-13 for more details on this section.

### Opportunity to Register to Vote section:

Inquire if the applicant's parent/guardian (over 18 years of age) would like to register to vote. If opportunity to vote is declined, AT THE INITIAL WIC CERTIFICATION APPOINTMENT, complete a declination form and maintain in the participant's file. In the event of an address change, the opportunity to register should be offered to parents or guardians of infant or child participants. If the parent/guardian declines, have him/her initial in the space provided. You do not need to complete a declination form.

### Documentation of Income, Residency and Identity section:

This section must be completed by a WIC staff member other than the person that certified nutritional risk eligibility. WIC staff should document proof of income, residency and identity in SWIS. Sign and date the form to certify WIC *income, residency and identity* eligibility conditions are met.