

# Local Agency Name WIC Nutrition Program

**Nutrition Assessment**

To: Fax:

The following may be helpful as you work to achieve positive health outcomes for:

Participant’s Name: WIC ID Number:

DOB:

Clinic:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Growth** | Date |  |  |  | **Comments:** |
| Height/length |  |  |  |
| Weight |  |  |  |
| Wt/length %ile |  |  |  |
| BMI/age %ile |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Iron Status** | Date |  |  |  | **Comments:** |
| Hgb |  |  |  |

**Nutrition Assessment:**

**Next WIC Appointment:**

## Release of Information:

* I give the WIC Program permission to send this information to my or my child’s doctor.
* The WIC program may talk to my doctor about the information on this form.

Signature Parent/Authorized Representative Date

Signature of WIC Program Staff Member Date

This institution is an equal opportunity provider.

Appendix CE-3-C Revised: 10/31/2019