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: _____ DOB:_____

WIC ID Number: _____ 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