North Carolina Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section
Nutrition Services Branch • WIC Program

WIC PROGRAM EXCHANGE OF INFORMATION: Infants and Children

Name of Client: _____ **Date of Birth:_____**

RETURN COMPLETED FORM TO:

I authorize the exchange of the information below between the WIC Program and my child's Health Care Provider. Parent's/Caretaker's Signature:_____ Date:_____	Local WIC Agency / Address / Phone Number

The following information is to be completed by the Health Care Provider.

1. Client is insured through (check one): ❒ Medicaid ❒ Other ❒ No health insurance
2. Document if client is ≤ 24 months of age: Birth Weight _____ Birth Length _____ Weeks Gestation _____
3. Enter date and results of ***most recent*** measurements / tests:

   Date: _____ Weight: _____

   Date: _____ Recumbent Length: _____ or Standing Height: _____

   Date: _____ Hemoglobin: _____ or Hematocrit: _____

   Date: _____ Blood Lead: _____ or ❒ Results not yet available
4. Immunization status (check one): ❒ Up-to-Date ❒ Not Up-to-Date
5. Medical conditions and medications:

6. Special instructions for nutritional support or feeding:

7. Would you like to receive a summary of nutrition services provided by the WIC Program staff? ❒ Yes ❒ No

Completed by:_____ Date:_____ Phone No.:_____
Signature/Title

SUMMARY OF NUTRITION SERVICES (*to be completed by the WIC Program Staff)*

Completed by:_____ Date:_____ Phone No.:_____
Signature/Title

The North Carolina WIC Program operates in all 100 counties in North Carolina.
For more information, go to www.nutritionnc.com or contact your local WIC Program.
This institution is an equal opportunity provider.

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WIC PROGRAM EXCHANGE OF INFORMATION: Women

Name of Client: _____ **Date of Birth:_____**

RETURN COMPLETED FORM TO:

I authorize the exchange of the information below between the WIC Program and my Health Care Provider. Client's Signature:_____ Date:_____	Local WIC Agency / Address / Phone Number

The following information is to be completed by the Health Care Provider.

1. Actual or expected date of delivery: _____
2. Pre-pregnancy weight (if available): _____
3. Enter date and results of ***most recent*** measurements / tests:

   Date: _____ Weight: _____ Date: _____ Height: _____

   Date: _____ Hemoglobin: _____ or Hematocrit: _____
4. Obstetric history:
5. Medical conditions and medications:
6. Special instructions for nutritional support or feeding:
7. Would you like to receive a summary of nutrition services provided by the WIC Program staff? ❒ Yes ❒ No

Completed by:_____ Date:_____ Phone No._____
Signature/Title

SUMMARY OF NUTRITION SERVICES (*to be completed by the WIC Program Staff)*

Completed by:_____ Date:_____ Phone No.:_____
Signature/Title

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