

WIC PROGRAM EXCHANGE OF INFORMATION: Infants and Children

Name of Client: _____

Date of Birth: _____

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: _____

RETURN COMPLETED FORM TO:

Local WIC Agency / Address / Phone Number

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

- Client is insured through (check one): Medicaid Other No health insurance
- Document if client is ≤ 24 months of age: Birth Weight _____ Birth Length _____ Weeks Gestation _____
- 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
- Immunization status (check one): Up-to-Date Not Up-to-Date
- Medical conditions and medications:
- Special instructions for nutritional support or feeding:
- 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

WIC PROGRAM EXCHANGE OF INFORMATION: Women

Name of Client: _____

Date of Birth: _____

I authorize the exchange of the information below between the WIC Program and my Health Care Provider.

Client's Signature: _____

Date: _____

RETURN COMPLETED FORM TO:

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

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..