### Missouri Department of Health and Senior Services

**WIC and Nutrition Services**

**WIC Certification – Infants and Children**  
(MOWINS Back-Up)

<table>
<thead>
<tr>
<th>Date</th>
<th>Agency Number</th>
<th>☐ Infant</th>
<th>☐ Child</th>
<th>☐ Addition</th>
<th>☐ Recert</th>
</tr>
</thead>
</table>

**Complete for Infants and Children**

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name</th>
</tr>
</thead>
</table>

- Hispanic or Latino:  
  - ☐ Yes  
  - ☐ No
- Race:  
  - ☐ White  
  - ☐ Black/African American  
  - ☐ American Indian/Alaskan  
  - ☐ Asian  
  - ☐ Native Hawaiian/Pacific

**Complete Demographics for Household**

- How did you hear about the WIC Program:  
  - ☐ Family Member  
  - ☐ Friend  
  - ☐ Health Care Provider
- Registered to Vote:  
  - ☐ Yes, I want to register and complete a voter registration application form  
  - ☐ No, I don’t want to register
- Type of Medical Home (where they receive their health care):  
  - ☐ HMO  
  - ☐ Hospital Emergency Room  
  - ☐ Local Health Dept.  
  - ☐ Medicaid Provider  
  - ☐ Private Physician/Clinic  
  - ☐ Other
- Marital Status:  
  - ☐ S  
  - ☐ M  
  - ☐ W  
  - ☐ D  
  - ☐ SEP  
  - ☐ DECL
- Educational Level of Authorized Representative:  
  - Grade Completed _______  
  - Years of College _______  
  - Unknown______
- Household Smoking:  
  - ☐ Yes  
  - ☐ No
- List referrals provided ____________________________

**Complete Demographics for Infants (0-11 months)**

<table>
<thead>
<tr>
<th>Birth Weight:</th>
<th>Birth Length:</th>
</tr>
</thead>
</table>

- Immunizations Reviewed  
  - ☐ Up to date  
  - ☐ Not up to date  
  - ☐ Did not check record  
  - ☐ Document not available
- Birth Facility:  
  - ☐ Hospital  
  - ☐ Home  
  - ☐ Other

**Complete Infants and Children (0 - 24 months)**

- Was the infant ever breastfed:  
  - ☐ Yes  
  - ☐ No
- Breastfeeding Now:  
  - ☐ Yes  
  - ☐ No
  - If no, record reason why stopped breastfeeding: ____________________________
- Amount of Breastfeeding:  
  - ☐ Exclusively breastfeeding  
  - ☐ More than ½ feedings are breastmilk  
  - ☐ Less than ½ feedings are breastmilk
- Date breastfeeding is verified: _________  
  - Date supplemental feeding began: _________
- Date solid foods began?  
  - ☐ Never  
  - ☐ Started: _________
- Premature  
  - ☐ Yes  
  - ☐ No  
  - Gestation Week _______

**Complete for all Infants and Children (0 - 59 months)**

| Current Weight | Current Height/Length | Blood Work:  
  - ☐ Hgb  
  - ☐ Hct |
|----------------|----------------------|-------------|
  - ☐ Recumbent  
  - ☐ Standing
- Results: _________  
  - Blood Work Date: _________

**Nutrition Education Topics**

- ☐ Initial Nutrition Education Contact (Date: ___________ )  
  - ☐ Other ____________________________

**Food Prescription**

- ☐ Milk and Cheese  
- ☐ All Milk  
- ☐ WIC 29  
- ☐ Standard Contract Formula ____________________________
  - ☐ Other ____________________________

**Complete for Children (24 – 59 months)**

- TV/Viewing (>2 years old): number of hours per day: _________

**Comments**

Schedule next appointment after information is entered in MOWINS, due to the possibility the person may be considered high-risk.
Schedule next appointment after information is entered in MOWINS due to the possibility the person may be considered high-risk.

**Missouri Department of Health and Senior Services**

**WIC and Nutrition Services**

**WIC Certification – Women**

(MOWINS BACK-UP)

<table>
<thead>
<tr>
<th>Date:</th>
<th>Agency Number:</th>
<th>Prenatal</th>
<th>Non-Breastfeeding</th>
<th>Breastfeeding</th>
<th>Addition</th>
<th>Recert</th>
</tr>
</thead>
</table>

**Complete for All Women**

- **Last Name:**
- **First Name:**

- **Hispanic or Latino:** □ Yes □ No
- **Race:** □ White □ Black/African American □ American Indian/Alaskan □ Asian □ Native Hawaiian/Pacific

- How did you hear about the WIC Program?
  - □ Family Member □ Friend □ Health Care Provider □ Household member on WIC □ Specify: __________________

- □ Registered to Vote: □ Yes, I want to register and complete a voter registration application form □ No, I don’t want to register □ Already registered □ Unknown

- **Type of Medical Home (where they receive their health care):** □ HMO □ Hospital Emergency Room □ Local Health Dept. □ Medicaid Provider □ Private Physician/Clinic □ Other: □

- **Marital Status:** □ S □ M □ W □ D □ SEP □ DECL

- **Educational Level:** _____ Grade Completed ______ Years of College ______ Unknown

- **Household Smoking:** □ Yes □ No

- **List Referrals Provided:** □ WIC □ CPA □ HPA □ WIC Certifier (WIC Cert), CPA

- **Current Height __________**
- **Current Weight __________**
- **Blood Work: □ Hgb □ Hct □ Lead Results: ____________**
- **Blood Work Date: ____________**

- **Nutrition Education Topics:** □ Initial Nutrition Education Contact (Date: ____________) □ Other ____________

- **Food Prescription:** □ Milk and Cheese □ All Milk □ WIC 29 □ Other ____________

<table>
<thead>
<tr>
<th>HPA, WIC Certifier (WIC Cert), CPA</th>
<th>CPA</th>
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**Complete for Prenatal**

- **Last Normal Menses Date:** __________
- **Month Prenatal Care Began:** __________
- **Pre-pregnancy Height:** __________

- **Pre-pregnancy Weight:** __________
- **Gravidity (total number of pregnancies regardless of outcome):** __________

- **Children Living:** __________
- **Number of WIC Pregnancies:** __________
- **Number of pregnancies greater than 20 weeks:** __________

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<thead>
<tr>
<th>In the Last 3 months, average number of cigarettes smoked/day:</th>
<th>In the Last 3 months, average number of alcoholic drinks/day:</th>
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**Multivitamin Consumption:**
- **How often did you take them a month prior to your pregnancy?** ____________
- **How often did you take them during your pregnancy?** ____________

<table>
<thead>
<tr>
<th>Have you ever had an infant who was:</th>
<th>□ Low Birth Weight □ Premature □ History Fetal or Neonatal Loss or 2 or more Spontaneous Abortion</th>
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<tr>
<td>Low Birth Weight</td>
<td>Premature</td>
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**Complete for Non-Breastfeeding and Breastfeeding Women**

- **Birth Facility:** □ Hospital □ Home □ Other __________

<table>
<thead>
<tr>
<th>Delivery Date:</th>
<th>Pregnancy Weight Gain:</th>
<th>Delivery Type:</th>
<th>□ Vaginal □ C-Section</th>
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<td>____________</td>
<td>____________</td>
<td>□ Vaginal □ C-Section</td>
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<tr>
<th>Outcome of Delivery:</th>
<th>□ Live Birth □ Fetal Death □ Miscarriage □ Neonatal Death</th>
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<td>Live Birth</td>
<td>Fetal Death</td>
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<th>Weight at Delivery:</th>
<th>Date Prenatal Care Began:</th>
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**MO 580-2933**

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(MOWINS Back-Up) (11-15)