

HIGH RISK CARE PLAN – CHILD WORKSHEET

Demographics

Client Last: _____ First _____ MI _____ Status: _____

Gender: Female Male DOB: _____

Group Data

Caregiver Last: _____ Caregiver First: _____ MI _____

Alternate Last: _____ Alternate First: _____ MI _____

Phone: _____ Msg.Phone: _____ Phone Notes: _____

Address: _____ City: _____ Zip: _____

_____ County: _____ City County

Mail: _____ City: _____ Zip: _____

BL: _____ in _____ 8ths BW: _____ lb _____ oz Bsfed: currently never stopped: _____ (date)

RD C

Date Service Provided: _____ Provider Type: WIC MSS Other _____

Prof. Interpreter Used Paper Copy

SUBJECTIVE

Medical Provider: _____

Caregiver Concerns: Growth Food Intake Other: _____

Appetite: Good Fair Poor Variable Food Supply: Adequate Inadequate

Familial Growth Patterns _____ Activity Level _____

Family Hx of Food Allergies _____

Psychosocial Concerns _____

Recent Health Concerns _____

Measures

Date: _____ Height: _____ - _____/8 Length: _____ - _____/8 Weight: _____ lb. _____ oz. Head Circ: _____ - _____/8

Date: _____ Height _____ - _____/8 Length: _____ - _____/8 Weight : _____ lb. _____ oz. Head Circ: _____ - _____/8

Date Hct/Hgb Taken: _____ Hct. _____ Hgb. _____ Notes _____

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OBJECTIVE

Meds: <input type="checkbox"/> Iron <input type="checkbox"/> Fluoride	Other: _____ <input type="checkbox"/> Vitamins <input type="checkbox"/> Minerals
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ASSESSMENT

PLAN

Client's Goal: _____

Program Goal: _____

Reinforce _____

Receive Instruction On: _____

Recheck: Hct./Hgb. Diet Weight

I: NUTRITION EDUCATION

Date	Topics	Handouts

I: CLIENT REFERRALS

Service	Has	Ref	Has App	NI	Service	Has	Ref	Has App	NI	Other
TANF					Doctor					
Medicaid					Dentist					
Food Stamps					Immunizations					
Child Support Enf.					Family Planning					
Other _____					Other _____					

EVALUATION

NOTES

Food Package: _____ **Food Pkg. Modifications.:** _____

Registered Dietitian: _____



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