# Connecticut WIC Program
# Child Nutrition Assessment Guidance

| Question | Suggested Action |
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| **Breastfeeding Screen**<br><br>**Has the child ever breastfed?**<br><br>**Is the child currently breastfeeding?**<br><br>**Date BF Ceased**<br>**Reason BF Ceased**<br>(You may also want to ask; Is your child taking expressed breast milk?)<br><br>**Is the child currently receiving any supplemental formula?**<br><br>**First formula at ___ weeks**<br><br>**Reason formula added**<br><br>**Verified date?**<br><br>How is breastfeeding going?<br><br>How many times is the child breastfeeding or given breastmilk in a day (24 hour period)?<br><br>Are there any concerns about breastfeeding? | **These questions are required for CT-WIC and CDC data collection.**<br>These questions should be asked until breastfeeding ceases for child participants.<br><br>Until breastfeeding has stopped, this screen must be updated and verified in order to issue eWIC benefits.<br><br>While these questions are not MANDATORY, they are needed to provide a complete assessment of breastfeeding status and or progress. At a minimum, we'd expect the # of times breastfed/day to be answered in order to establish adequacy and provide counseling about extended breastfeeding. |
| **Health Screen, Pg. 1**<br><br>**1. Do you have any questions or concerns about your child's?**<br><br>Please check one or more:<br><br>Weight/Growth<br>Eating habits<br>Appetite<br>Health<br>No concerns<br>Other | The Nutritionist can choose how to begin CT-WIC Guided Script to facilitate the flow of the appointment, it may be necessary to toggle between the Lab and Health Screens as you discuss growth.<br><br>Use this question to assess what concerns the parent has regarding her/his child. This allows you to focus in the counseling portion of the visit on her/his concerns. Briefly address the issue raised by the parent then explain gathering additional information helps you to better understand the situation and allows you to ask more focused questions and provide possible solutions/referrals.<br><br>It is also a good practice to give the participant an idea of how long you expect the visit to take up front. It is one strategy to keep the visit on track. Often times, families situations can be complicated requiring more time than originally planned. If this happens, you may want to check in with the participant to reassure the information gathered is important and to determine if the additional time can be accommodated. If not, make appropriate follow-up plans. |

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| Refer to specific risks related to infant/child growth are:<br><br>FNS Nutrition Risk Criteria<br><br>#103 *Underweight/At Risk of Underweight*<br>#113 *Overweight/Obese*<br>#114 *At Risk of Overweight*<br>#115 *High Weight for Length*<br>#121 *Short Stature* | **Sharing growth information with parents: Note, all Anthropometric and Biological data are found on the Lab Screen(s)**<br>▪ Show plotted measurements.<br>▪ Reassure parent that growth is normal if it consistently follows the curve of the chart.<br>▪ Point out that growth patterns are best evaluated over a period of time vs. one single plot.<br>▪ For infants/children Birth-24 months, growth is assessed based on the 2006 World Health Organization (WHO) international growth standards. In 2010, CDC recommended use of Birth to 24-month age/gender specific charts based on WHO international growth standards. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5909a1.htm?s_cid=rr5090a1_w<br><br>With the transition to use of optimal growth (growth standard) vs. a reference population, the Nutritionist may need to explain the difference to participants especially if the infant/child's provider isn't using the same growth curves.<br>Refer to Breastfeeding Content Sheet: **Supporting Breastfeeding Using the WHO Growth Standards 0-24** for consistent messages to communicate to parents.<br><br>▪ When the child transitions from the Birth-24 month curves to the 2000 CDC age/gender specific growth charts keep in mind these points apply:<br>▪ Child is moving from recumbent length to standing height measurements. Note that the difference between recumbent length and stature in national survey data is approximately a 0.8 cm (¼ inch) difference. Standing height measures less than recumbent length.<br>▪ Breastfed reference population to a primarily formula-fed reference population.<br>▪ Weight-for-length chart to BMI-for-age chart.<br>▪ One set of cutoff values to another.<br>▪ Adjust for gestational age for infants born < 37 weeks until child turns 24 months chronological age.<br><br>**If measurements obtained are different than what parent reports MD obtained:**<br>▪ Point out measuring technique used by WIC staff (child measured using board with flat surface for head and feet; child undressed to dry diaper; child weighed without heavy clothing, shoes)<br>▪ Scales routinely calibrated<br>▪ Growth corrected for gestational age until 24 months<br>Refer to Consistent Nutrition Education Messages **Childhood Overweight and Obesity Guide for BMI Assessment and Effective Communication with Families.**<br><br>This on-line module discusses the importance of accuracy and reliability in taking anthropometric measurements. http://depts.washington.edu/growth/ (MCHB Growth Chart Training) and provides review of appropriate anthropometric equipment selection, calibration and measurement techniques. See also, **https://connect.wisconsin.gov/dhswicweighmeasure/** for more assistance on anthropometric measurements in WIC. |

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| | ***Infant/Child (Birth-24 months) with FNS Nutrition Risk Criteria #114 or #115 At Risk for Overweight or High Weight for Length*** Review *Implications for WIC Nutrition Services* sections of 114 *At Risk for Overweight* or 115 *High Weight for Length* for counseling tips and how to discuss with families what these risks may imply. Parents or caregivers of infants and children identified with these risks can be provided information on actionable prevention strategies for overweight and obesity including discussions on recognition of satiety cues and age appropriate physical activity or play.<br><br>***Child (2-5 years) with FNS Nutrition Risk Criteria #113 or #114 (Obese, Overweight or At Risk for Overweight)*** Review *Implications for WIC Nutrition Services* sections of #113 Obese, *#114 Overweight or At Risk for Overweight* for counseling tips and how to discuss with families what these risks may imply. Parents or caregivers of children identified with these risks can be provided information on actionable prevention strategies for overweight and obesity including discussions on recognition of satiety cues, promotion of healthy eating and age appropriate physical activity or play.<br><br>***Child with inconsistent growth*** (increase or decrease of >2 channels in wt/length or BMI/age over 6 mo.):<br>▪ *As appropriate, have the WIC participant/guardian sign an authorization of release to send a nutrition assessment to the Health Care Provider communicating concerns for growth and requesting feedback on the stated plan.*<br>▪ ***NOTE:*** *Inconsistent growth is not: <5th%ile weight/height, >95th%ile weight/height, or single growth plots at >95th%ile or <5th%ile.*<br><br>***Child with inadequate growth*** (average weight gain < 2.7 oz./month or < 1# over 6 month period):<br>▪ CT-WIC auto assigns, #135 Inadequate Growth<br>▪ Refer nutrition assessment to physician with concerns and areas addressed with parent<br><br>**Head Circumference:** WIC staff doesn't routinely measure head circumference in clinic. However, if head circumference measurements are available from the provider or if the risk factor, "Low Head Circumference" (FNS Nutrition Risk Criterion #152) is selected on the certification form; the Nutritionist should follow up with the provider. This is to determine if they have based their assessment on the 2006 World Health Organization (WHO) international growth standards, Birth to 24-month age/gender specific charts or the 2000 CDC age/gender specific growth charts. WIC staff can use the HC information to re-plot on the Birth-24 month charts. This risk factor applies to infants and children up to 24 months of age. |
| **2. Does your child have any health or medical issues/conditions?**<br>Yes/No<br><br>For subsequent visits you may want to phrase as- Do you or your child have any changes to your health since the last visit? Please describe. | If **yes**/responded or selected—<br>Find out more information, document in free text box and assign risk as appropriate. Ask for medical documentation when appropriate.<br><br>If information about child's pediatrician and/or medical conditions is on the medical referral form or certification form the parent brings to the appointment, verify and document health/clinical and medical risk factors. |

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| *For new clients:* Who is your child's doctor?<br>When was his/her last appointment? | If no MD, refer as appropriate. **Participant Information Screen** has a field that records medical provider information. |
| **3. Does your child have any of these allergies?**<br>Milk<br>Egg<br>Soy<br>Peanut<br>None | CT-WIC auto-assigns FNS Nutrition Risk Criterion #353 *Food Allergy* based on checked boxes. Use this information to provide appropriate counseling and food package tailoring. Allergy FLAG will be RED on Food Prescription Screen. |
| 4. Does the child go for regular dental check-ups?<br>Last visit? | If child has seen a dentist, affirm parent for taking care of child's oral health. Include date of last hygiene visit. If no dentist, make appropriate referrals. |
| Additional questions regarding dental care that you may ask.<br><br>How often are your child's teeth brushed? Has your child been to the dentist?<br>*For new clients:* Who is your child's dentist? | General oral health guidelines:<br>▪ Encourage **parent** to brush the child's teeth a minimum of twice/day. Children are not capable of doing an adequate job of brushing on their own until they are about 7 or 8 years old. After mealtimes, if a toothbrush is not available, have child drink water to rinse the mouth.<br><br>The following questions/guidance can be asked/provided in conjunction with beverage/fluid questions in the diet-related section.<br>▪ Ask parent what, if anything, the child drinks to fall asleep. If a beverage is provided to child when he is falling asleep:<br>1. Ask what it is provided in (bottle, sippy cup)<br>2. Remind parent that, after brushing the teeth at night before bedtime, the only beverage that should be offered is plain water. |
| **5. Does your child have any dental problems?**<br>If yes, please describe. | |
| 6. What medicines or supplements do you give your child?<br><br>Check all that apply:<br>Vitamins/Minerals<br>Herbs<br>Herbal Supplements<br>Medications<br>Other<br><br>Why?<br>Based on assessment and if applies, Nutritionist may assign #425.7 *Feeding dietary supplements with potentially harmful consequences* (*Excessive Supplementation*) or #425.8 Routinely *not providing dietary supplements recognized by public health policy* | This question provides an opportunity to learn about various supplements, vitamins and medications the client is giving to her child. Vitamin D is a necessary dietary supplement per *AAP Clinical Report: Prevention of Rickets and Vitamin D deficiency in infants, children and adolescents (2008.)* Recommendation is 400 IU of vitamin D children who are ingesting less than 1liter per day of vitamin D-fortified milk or formula.<br><br>If the child is taking a multivitamin containing 400 IU of vitamin D, they are meeting their vitamin D requirement. Since 1 quart of milk is in excess of the recommended **2 cups of milk per day for pre-school children, most children will require a supplement.** Children consuming more than the recommended 2 cups of milk per day on a consistent basis should be assessed for overall dietary intake, eating pattern and weight. Parental education should focus on meeting the dietary guidelines for all food groups and eating a variety of foods rather than trying to meet vitamin D requirements through excess milk consumption.<br><br>Ask about use of any supplements, including herbal preparations and teas. If necessary, research nutrition implications of specific medications as well as vitamins or supplements. Refer to health care provider as needed. |

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| **7. Does your child regularly eat things that are not food?**<br><br>**Check all that apply:**<br>Paper<br>Dirt<br>Pet Food<br>Paint Chips<br>Crayons<br>Other | If **yes** selected, CT-WIC assigns FNS Nutrition Risk Criterion #425.9 C*ompulsively ingesting non-food items (pica)*. Provide information/referrals as appropriate. |
| **Household Smoking**<br><br>**8. Does anyone (living in your household) smoke inside the home?**<br><br>CT-WIC auto-assigns FNS Nutrition Risk Criterion #904 *Environmental Tobacco Smoke* if "Yes" checked. | **These questions are required for CT-WIC and CDC data collection.** It is also in the Federal regulations and CT's State Plan to provide pregnant women and parents of children information on the risks of tobacco, drugs and alcohol. These can be sensitive questions to ask/answer so be aware and use cues from the participant when using probing questions.<br><br>▪ Ask about second hand smoke exposure. If parent or guardian is a smoker, emphasize that it will be more difficult to quit with other smokers around. Discuss need for smoke-free environment for baby/children. Stress that second hand smoke will stay on clothing and hand, and that all smokers should change clothes and wash hands prior to holding baby.<br><br>▪ Ask about parent's tobacco use and desire and/or plans to quit. Ask about methods to quit that have been used. Refer to the Connecticut **QUIT**LINE 1-866 END-HABIT (1-866-363-4224) |
| **Nutrition Screen(s)**<br>**Mealtimes and Places**<br><br>**1. Tell me about your child's meals and snacks.**<br><br>**2. How would you describe feeding time with your child?**<br><br>3. How often do you have family meals?<br><br>4. What do you do, if your child won't eat what you've offered?<br><br>5. How many times a week does your child eat:<br>Fast foods/restaurant foods<br>At daycare/school<br>At family/friends' house | This series of questions/screens now replace the traditional food frequency/24 recall. The goal is to use these questions to engage the parent in conversation about her child's eating habits and mealtime behaviors. These questions do not all have to be discreetly answered by each participant, every visit. However, questions that relate to each of the broad topic areas: Mealtimes, Foods, Drinks and Healthy Habits should be asked at each certification/re-certification appointment to ensure a complete WIC nutrition assessment is performed. At a minimum, bolded questions on these screens are required for initial certification and re-certification appointments.<br><br>Some general guidelines for mealtimes:<br><br>▪ Children thrive with structure in all areas of their lives. Regular feeding routines are an example of this.<br>▪ Since stomachs are still small, they need to eat every 2-3 hours. A daily schedule of 3 meals and 2-3 snacks is important.<br>▪ When provided with a structured feeding schedule, children will learn to trust that, if they do not eat much at a meal, there will be another feeding in a reasonable time period.<br>▪ Parents can role model for their child by eating a variety of foods and practicing desired mealtime behaviors. *If necessary, ask about the parent's food preferences and eating habits.*<br>▪ If the child is aware of the parent's specific food likes/dislikes, the child has too much information.<br>▪ Because mealtime is also a social time, children eat better when they eat with others. |

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| Other questions:<br>How often does your child eat the same foods as the rest of the family? | ▪ Impose limits on unacceptable mealtime behavior without controlling amount of food child wants to eat.<br>▪ Use non-food items to reward or discipline child, such as stickers, trips to the playground, a new game, etc.<br>▪ It is normal for children to be wary of trying new foods—they may need to touch, smell, feel and *then* taste before eating. Be prepared to offer new/challenging foods many times before they agree to eat it. Offer new food even if child has rejected it in the past.<br>▪ Reassure parent that it's ok for toddler to get familiar with new food by putting it into and taking it back out of the mouth—this is the process of becoming familiar with a food.<br>▪ Introduce new food in a neutral way. Talk about the color, shape, aroma and texture, but not how it tastes.<br>▪ Trying new foods takes time, so mealtimes should be relaxed but never prolonged.<br>▪ Well-balanced meals and snacks + Positive eating environment = Well-nourished child. Children need a pleasant, structured mealtime environment.<br>▪ Avoid letting child eat/drink in the car<br>▪ Pull high chair up to the table to include young toddler in family meal.<br><br>Based on the information gathered, you may provide information/resources to address the client's concerns, questions or identified barriers to positive health outcomes. |
| **Nutrition Screen(s)**<br>**Foods, Drinks and Healthy Habits**<br><br>**6. Do you feel your child is eating enough of these foods or are you offering these foods on most days?**<br>**Yes/No**<br><br>Milk/Yogurt/Cheese<br>Meat/Fish/Eggs/Beans/Peanut Butter/<br>Fruits/Vegetables/Salads<br>Bread/Cereal/Pasta/Rice<br><br>7. Are there any foods you avoid feeding to your child or he/she cannot eat?<br>If yes, what foods?<br><br>8. Is your child on a kosher diet? Yes/No<br>If Yes, Kosher flag is highlighted on Food Prescription Screen.<br><br>**9. What do you like/dislike about your child's eating?**<br>Excessive? Yes/No | This series of questions now replace the traditional food frequency or 24 recall. The goal is to use these questions to engage the parent in conversation about her what foods/beverages she/he is offering to her child. These questions do not all have to be discreetly answered by each participant, every visit. However, questions that relate to each of the broad topic areas: Mealtimes, Foods, Drinks and Healthy Habits should be asked at each certification/re-certification appointment to ensure a complete WIC nutrition assessment is performed.<br><br>Refer to the age appropriate **Project ReNEW Feeding Guide and accompanying Guidelines for Use** for specific nutrition information.<br><br>Some additional counseling tips/information to share with parents as appropriate based on feedback from asking these questions.<br><br>▪ Toddler appetites can be erratic and vary from day to day. In order to support a healthy appetite, encourage parent to avoid ad lib beverages or snacks close to meal times. 4-6 oz of milk at each meal and snack, and 4 oz of juice all day is plenty.<br>▪ Because toddler growth is slowing down, appetites will naturally decrease. Preschoolers have an increased appetite and interest in foods.<br>▪ It's normal for amounts eaten to vary from meal to meal and day to day. Offer small servings of food and allow the child to determine how much he/she wants to eat. If child has food allergy or family history of food allergy-Counsel parent on delayed introduction of common allergenic foods (peanuts, tree nuts, shellfish, eggs, citrus and possibly wheat, corn or dairy for those especially sensitive) for toddlers.<br>▪ Toddlers' bowel movements have no "normal" number or schedule, individual patterns depends on what he/she eats and drinks, activity level, speed of digestion and removal of waste. Common reasons for constipation include:<br>**Eating too many low-fiber foods** such as milk, cheese, yogurt, or peanut butter and not enough fruits, vegetables, and whole grains. |

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| Optional additional questions not in CT-WIC-<br>What are some foods you think your child eats too much of?<br><br>10. Does your child feed him/herself with the following? Check all that apply.<br>Fingers<br>Spoon<br>Fork<br>Other<br>Not self-feeding<br><br>**11. Does your child drink any of these beverages daily or on most days? Check all that apply.**<br>(Variety of selections) | **Toilet anxiety** or feeling pressured about toilet training, a child might start deliberately withholding stools. If he/she shows all the signs of straining to have a bowel movement — stiffening her body, arching her back, and getting red in the face — but nothing comes out, she may actually be trying to hold it in. Even if a child is potty-trained, not taking enough time on the toilet to completely empty her bowel can lead to a buildup of feces that causes the colon to stretch and cramp. An enlarged colon can lead to larger-than-normal, difficult-to-pass stools, making your child even more reluctant to use the potty.<br>**Dehydration.** If your toddler isn't getting enough liquids, her system will respond by absorbing more fluid from whatever she eats or drinks — and from the waste in her bowels, as well. This can result in hard, dry bowel movements that are difficult to pass.<br>**Lack of activity.** Movement helps blood flow to your toddler's digestive system.<br>▪ Refer parent who is concerned re: chronic constipation to the pediatrician.<br>▪ An occasional loose stool is generally not a problem but if a toddler's bowel movements *suddenly* change- i.e. has increased stools and passes looser, more watery stools — then it's probably diarrhea. Preventing dehydration is key. If the child is otherwise healthy and is getting plenty of fluids, the diarrhea will probably clear up in a couple of days. The list of possible causes for diarrhea is long. It could be caused by a viral or bacterial infection. It might also be the result of a parasite, a course of antibiotics, or something the child ate.<br>▪ **Too much juice** (especially fruit juice containing sorbitol and high levels of fructose) or too many sweetened drinks can upset a child's tummy and cause him to have loose stools. Cutting back the amount should solve the problem in a week or so. The American Academy of Pediatrics (AAP) recommends that you give your toddler no more than one small glass (about 4 to 6 ounces) of juice a day.<br><br>▪ Refer the parent to the pediatrician if the child has diarrhea and doesn't seem to be improving after 24 hours.<br><br>▪ Also, advise the parent to call the pediatrician if the child has diarrhea and any of the following:<br>-vomiting multiple times<br>-signs of dehydration: such as dry mouth and infrequent urination (less than every six hours)<br>-blood in his stool or black stool<br>-a high fever-103 degrees Fahrenheit (39.4 degrees Celsius) or higher<br><br>▪ *Dessert*—Children do not understand why dessert items come after the rest of a meal. When offered separately, dessert is viewed as something special or a "treat". When this becomes an issue, try serving one age-appropriate dessert portion alongside the meal, so it does not become the "reward". The child will soon learn that dessert alone will not fill them up *as long as parents will not give in to "hunger cries" soon after the meal*. Parents must remain consistent with regular meal and snack times. Dessert does not always mean "sweet things". Fruit can be considered a dessert item.<br><br>▪ Make sure foods offered are healthy choices; avoid high sugar empty calorie foods.<br>▪ Remind parent not to struggle with child over food.<br>▪ Reassure parent that if the child does not eat everything on the plate at a meal, it's ok to trust that he/she is full. |

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| **12. Does your child eat:**<br>Uncooked hot dogs or deli meats<br>Soft cheeses including, feta or Mexican style cheeses- queso blanco<br>Undercooked, raw eggs<br>None | If any of these items are checked CT-WIC auto assigns, FNS Nutrition Risk Criterion #425.5 *Feeding food that may be contaminated with harmful microorganisms*. However, assess for frequency and provide appropriate counseling. Provide current recommendations for consumption of these foods during childhood.<br>Reminder to review choking hazard foods:<br>▪ Whole grapes, Raisins, Nuts & Seeds, Pretzels, Spoonfuls of peanut butter, Raw carrots, other Dried fruit and Popcorn<br>▪ Hard candy, Chips, Marshmallows, hot dog (coin cut) |
| **13. Does your child drink from the following? Check all that apply.**<br><br>Baby bottle<br>Sippy cup<br>Regular cup<br>Cup with Straw<br><br>If your child drinks from bottle or Sippy cup, when does he/she use it?<br><br>At bed at night or naptime? If yes, what is in it? | Encourage use of open-mouth cup rather than a spill proof or sip cup. Use this question to reinforce age appropriate anticipatory guidance, proper oral health behaviors and weaning strategies. Affirm parent for any progress made.<br><br>If Baby bottle is selected, and child is >14 months, CT-WIC will auto-assign, FNS Nutrition Risk Criterion #425.3 *Routinely Using Nursing Bottles, Cups or Pacifiers Inappropriately*. If bottles aren't used, but sippy cups or cups are being used inappropriately, Nutritionist must manually select #425.3 from drop down menu on Nutrition Risk Screen. |
| **14. How many hours a day does your child have screen time (TV, video games, computer, tablet, cell phone)?**<br><br>>0 and <1,<br>1, 2, 3, 4, 5+ hours<br>None or Unknown | This question allows you the opportunity to ask the parent about various sedentary activities and encourage age appropriate play. For additional child activity resources developed for WIC check out<br>WIC Works Resource System Fit WIC materials at:<br>https://wicworks.fns.usda.gov/wicworks//Sharing_Center/gallery/families.html |
| **Food Security**<br><br>**15. Does your family have enough food?**<br><br>**16. Do you have access to a refrigerator and stove/hot plate?**<br><br>17. Do you have adequate storage (for food)? | This question allows the nutritionist to gauge household food security and provide appropriate referrals. If referrals are made, document in CT-WIC, Referrals Screen.<br><br>If No, then Inadequate Storage FLAG is highlighted RED on Food Prescription Screen. |