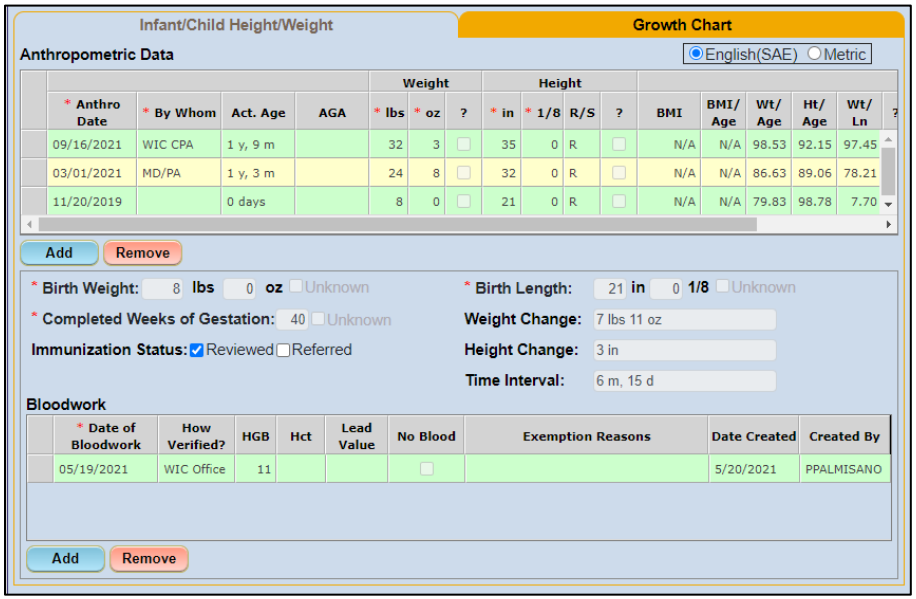
Connecticut WIC Program
Child Nutrition Assessment Guidance

The Nutrition Assessment Guidance provides an overview of the CT-WIC Screens including mandatory questions **(in bold)** and suggested probing questions. This tool can help you provide appropriate nutrition assessment to participants and identify and assign appropriate risks and is meant to be used in conjunction with the Infant/Child Certification Form and Supplement to Certification Form.

In the Suggested Actions column there are helpful links, references to Nutrition Risks that should be either auto-assigned or manually assigned by the Nutritionist based on the participant response.

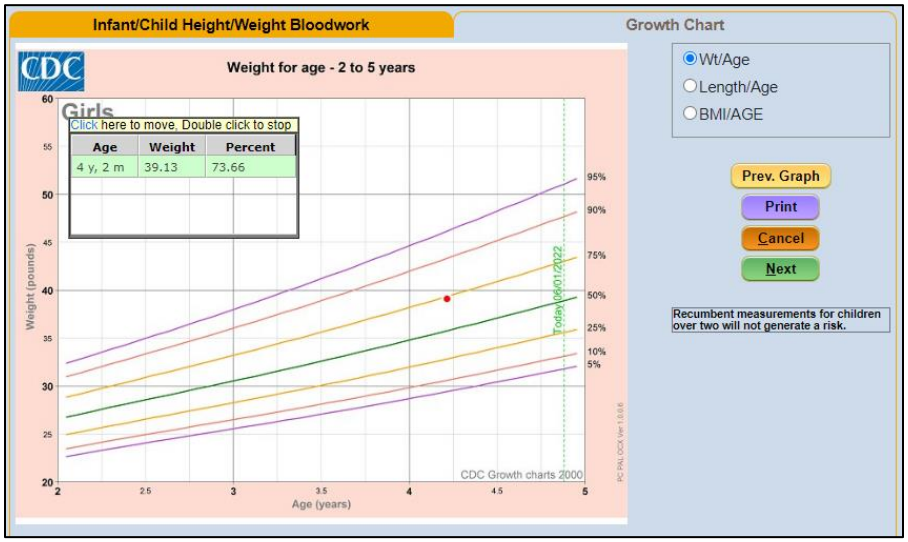
The link to https://connecticut.wicresources.org/ Connecticut's online nutrition education resources for staff and participants, is referenced in this tool as well.

Question	Suggested Action
Lab Screen  **CT-WIC Lab Screen – Children** **Anthropometric Data** *Data can be entered or viewed as **English (SAE)** or **Metric** by selecting the option at the top right of the screen.	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. Refer to specific risks related to infant/child growth are: ***FNS Nutritional Risk Criteria***

FNS Risk #	FNS Risk Description	Category
	Anthropometric	
103	Underweight/At Risk of Underweight	Infants, Children
113	Obese	Children 2-5 Years of Age
114	Overweight or At Risk of Overweight	Infants, Children
115	High Weight for Length	Infants, Children <24 Months of Age
121	Short Stature	Infants, Children
134	Failure to Thrive	Infants, Children
141	Low Birth Weight and Very Low Birth Weight	Infants, Children <24 Months of Age
142	Preterm or Early Term Delivery	Infants, Children <24 Months of Age
151	Small for Gestational Age	Infants, Children <24 Months of Age
152	Low Head Circumference	Infants, Children <24 Months of Age
	Biochemical	
201	Low Hematocrit/Low Hemoglobin	All Categories
211	Elevated Blood Lead Levels	All Categories

Birth and Growth Data (middle of screen)

***Completed Weeks of Gestation:** When <37 weeks is entered in this field, CT-WIC will automatically calculate the AGA (Adjusted Gestational Age) field in the Anthropometric grid once the infant reaches 40 weeks of age. AGA will continue to be calculated until the child is 24 months (2 years) of age.



CT-WIC Lab Screen – Growth Chart, Child

Child growth charts can be accessed on the Lab screen Growth Chart tab. The following growth charts can be viewed for children: Weight/Age, Length/Age and BMI/Age. Charts can be printed if a participant desires a copy.
NOTE: BMI is not calculated until children reach age 2.

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=rr5909a1_w

- 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. (***Refer to Breastfeeding Content Sheet: Supporting Breastfeeding Using the WHO Growth Standards 0-24 months)*** for more information about how to interact with pediatricians about infants' growth assessment.)
- When the child transitions from the Birth to 24-month curves to the 2000 CDC age/gender specific growth charts keep in mind these points apply:
  - Child is moving from recumbent (reclined) 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.

**CT-WIC defaults the "R/S" (recumbent/standing) field to "R" from 0 to 24 months of age. When the child is 2 years of age and older, the "R" will change to "S" automatically.*

  - Breastfed reference population to a primarily formula-fed reference population.
  - Weight-for-length chart to BMI-for-age chart.
  - One set of cutoff values to another.

***Sharing growth information with parents:* Note, all Anthropometric and Biological data are found on the Lab Screen(s)**

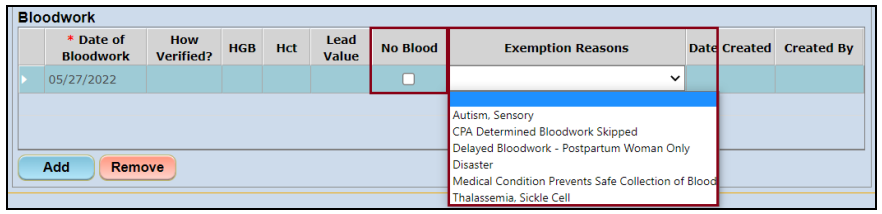
- Show or print out plotted measurements
- Reassure parent that growth is normal if it consistently follows the curve of the chart
- Point out that growth patterns are best evaluated over a period vs. one single plot

Infant (Birth-24 months) with #115 High Weight for Length or #114 At Risk for Overweight

Training tip: This online module discusses the importance of accuracy and reliability in taking anthropometric measurements, https://depts.washington.edu/growth/index.htm (MCHB Growth Chart Training) and reviews appropriate anthropometric equipment selection, calibration, and measurement techniques.

***Bloodwork**

This grid does not become enabled until an infant is 9 months of age.
Refer to WIC Policy 200-08 Nutrition Assessment and Risk Determination for more information on the bloodwork periodicity schedule and the policy on selecting an Exemption Reason. Note the option, CPA Determined Bloodwork Skipped, should be used rarely, if ever and only while awaiting documentation of a valid Exemption Reason for a maximum of 3 months.



Review *Implications for WIC Nutrition Services* sections of #115 *High Weight for Length* or #114 *At Risk for Overweight* for counseling tips and how to discuss with families what these risks may imply. Parents or caregivers of infants 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.

If measurements obtained are different than what parent reports MD obtained:

- Point out measuring technique used by WIC staff (baby on measuring board with flat surfaces for head and feet; infant undressed to dry diaper for weight)
- Scales are routinely calibrated.

Infant with inconsistent growth (increase or decrease of >2 channels on growth chart):

- 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.

Head Circumference: Connecticut WIC staff doesn't routinely measure head circumference in clinic. However, if head circumference measurements are available from the provider or FNS Nutrition Risk Criterion #152 *Low Head Circumference* (#9) is selected on the certification form the Nutritionist should follow up with the provider.

Anemia Prevention and Counseling:

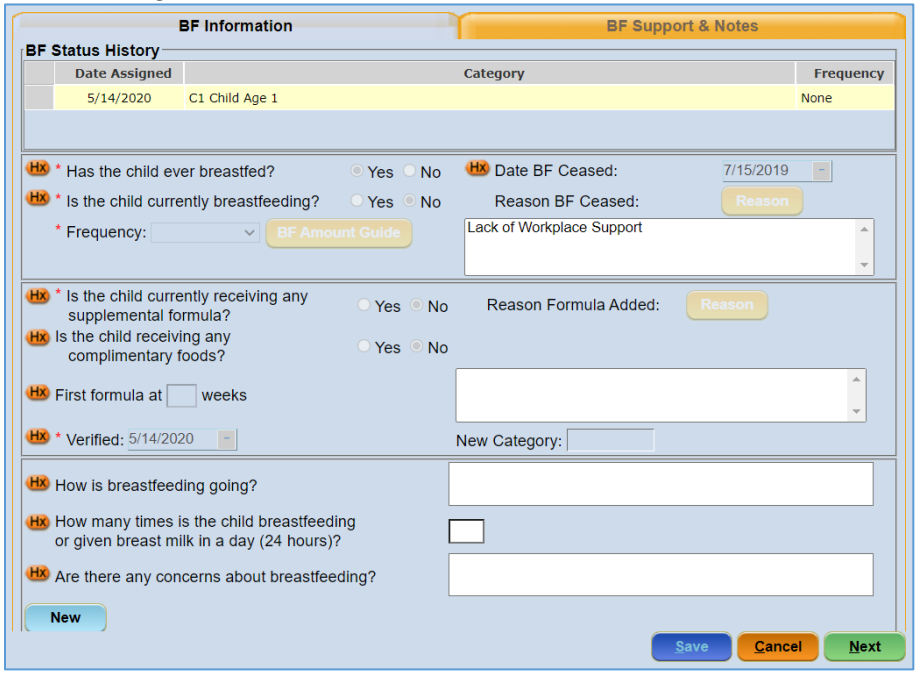
For anticipatory guidance on the anemia prevention, or if anemia is indicated, discuss the following with the parent or caregiver:

- Foods high in iron and vitamin C
- Impact of untreated iron deficiency anemia
- Retest within 6 months of original test (if anemia indicated) Pronto can be used for child participants 15 months and older as needed.
- Referral to provider for use of an iron supplement (if anemia indicated)

Elevated Blood Lead Level: Lead screening is the law in Connecticut. It is required to test children twice between the ages of 9 and 35 months. Most

	providers will test at 12 months and 24 months. If lead levels are available from the provider, results must be documented in CT-WIC. If an elevated blood lead level is indicated, discuss the following with the parent or caregiver: • Eating a variety of foods, importance of foods high in calcium, iron, and zinc. • Impacts of untreated lead poisoning • Referral to provider for further testing, treatment • Referral to a Regional Lead Treatment Center (LRTC) in Connecticut (CCMC in Hartford and Yale-New Haven Hospital in New Haven) • Referral to Local Health Department Visit the State of Connecticut Department of Public Health Lead Information webpage.

Breastfeeding Screen



CT-WIC BF Information Screen

Has the child ever breastfed? Yes/No

Is the child currently breastfeeding? Yes/No

Frequency: *Exclusive, Fully, Mostly, Limited*
Note: Exclusive should not be selected as an option for any participant over 6 months of age or when complementary foods have been offered.

These questions are required for CT-WIC and CDC data collection.
These questions should be asked until breastfeeding ceases for child participants.

Until breastfeeding has stopped, this screen must be updated and verified to issue eWIC benefits.

Document whether the child has breastfed or not previously. This can be any breastfeeding of any quantity. For example, this could be if the child breastfed 1 time during the hospital stay or if the child is currently breastfeeding. If there were no breastfeeds at all, the answer to this question should be NO. You may also want to ask; Is your child taking expressed breast milk?

<u>For C1 categories still breastfeeding, the Nutrition should document the final breastfeeding frequency in infancy. This allows the system to capture the last breastfeeding intensity for our records.</u>
For example:
This child prior to the 1-year certification was Mostly breastfeeding. Select *Mostly* from the **Frequency** dropdown.

*Capturing the breastfeeding frequency in this manner for a child will help document the most current frequency prior to turning age 1.

Date BF Ceased **Reason BF Ceased**	When a child has been breastfed, but is no longer breastfeeding, a Date BF Ceased must be entered. It can be difficult to obtain this date especially if breastfeeding ceased some time ago. Ask probing questions such as, "How many weeks do you think you breastfed?", "How long ago did you stop breastfeeding? A week, a month?", "Do you around the time of the month that you stopped breastfeeding?" to determine the Date BF Ceased. During the conversation on determining the Date BF Ceased, inquire about the reason why breastfeeding ended.
Is the child currently receiving any supplemental formula?	Determine if the child is receiving any supplemental formula and/or medical foods.
Is the child receiving any complimentary foods?	Complimentary foods refer to foods provided to infants that are not considered breastmilk or formula.
First formula at ___ weeks	Determine the age, in weeks, when the child was first provided with formula. Fill in the number of weeks when formula was added. Note, if formula was added anytime from 0-7 days, enter "0" week.
Reason formula added	Inquire about the reason why formula was introduced to the child.
Verified date?	This should be reflected as the date the New Category for the participant was "verified" based on the answer to the preceding breastfeeding questions.
How is breastfeeding going? How many times is the child breastfeeding or given breastmilk in a day (24 hour period)? Are there any concerns about breastfeeding?	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 to establish adequacy and provide counseling about extended breastfeeding.

Health Screen

CT-WIC Health Screen

The Nutritionist can choose how to begin the 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.

1. Do you have any questions or concerns about your child's?

Please check one or more:

Weight/Growth
Eating habits
Appetite
Health
No concerns
Other

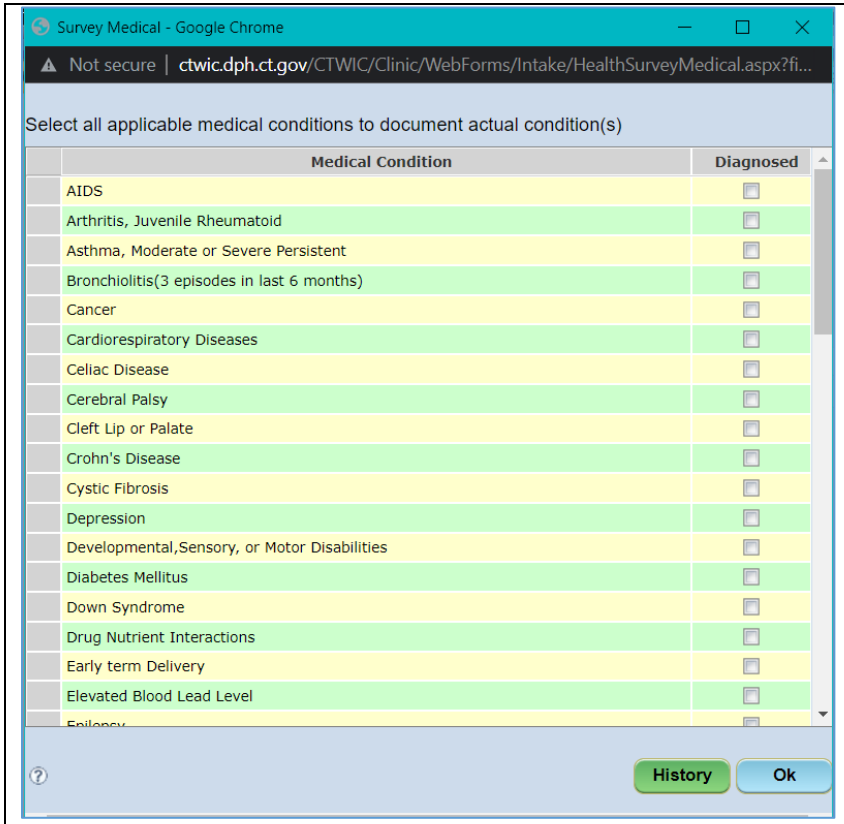
Use this question to assess what concerns the parent has regarding their child. This allows you to focus in the counseling portion of the visit on their concerns. Briefly address the issue raised by the parent then explain gathering additional information helps you to better understand the situation and allows you to ask more focused questions and provide possible solutions/referrals.

It is also a good practice to give the parent 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.

Refer to specific risks related to infant/child growth: FNS Nutrition Risk Criteria: These risks listed under the Anthropometric section on the Certification Form #103 *Underweight/At Risk of Underweight* #113 *Overweight/Obese* #114 *At Risk of Overweight* #115 *High Weight for Length* #121 *Short Stature*	**Sharing growth information with parents: Note, all Anthropometric and Biological data are found on the Lab Screen(s)** Show plotted measurements. Reassure parent that growth is normal if it consistently follows the curve of the chart. Point out that growth patterns are best evaluated over a period of time vs. one single plot. 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=rr5909a1_w 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. Refer to Breastfeeding Content Sheet: **Supporting Breastfeeding Using the WHO Growth Standards 0-24** for consistent messages to communicate to parents. When the child transitions from the Birth to 24-month curves to the 2000 CDC age/gender specific growth charts keep in mind these points apply: 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. Breastfed reference population to a primarily formula-fed reference population. Weight-for-length chart to BMI-for-age chart. One set of cutoff values to another. Adjust for gestational age for infants born < 37 weeks until child turns 24 months chronological age. **If measurements obtained are different than what parent reports MD obtained:** 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)

	Scales routinely calibrated Growth corrected for gestational age until 24 months Refer to Consistent Nutrition Education Messages **Childhood Overweight and Obesity Guide for BMI Assessment and Effective Communication with Families.** This on-line module discusses the importance of accuracy and reliability in taking anthropometric measurements, (MCHB Growth Chart Training) https://depts.washington.edu/growth/ and provides review of appropriate anthropometric equipment selection, calibration, and measurement techniques. ***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. ***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. ***Child with inconsistent growth*** (increase or decrease of >2 channels in wt/length or BMI/age over 6 mo.): *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.* ***NOTE:*** *Inconsistent growth is not: <5th%ile weight/height, >95th%ile weight/height, or single growth plots at >95th%ile or <5th%ile.* ***Child with inadequate growth*** (average weight gain < 2.7 oz./month or < 1# over 6 month period):

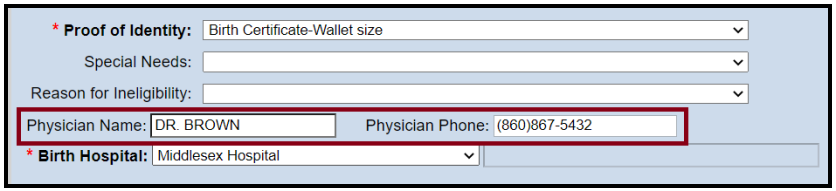
	CT-WIC auto assigns, #135 Inadequate Growth Refer nutrition assessment to physician with concerns and areas addressed with parent **Head Circumference**: WIC staff doesn't routinely measure head circumference in clinic. However, if head circumference measurements are available from the provider or if 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? Yes/No	Ask for medical documentation when appropriate. If no MD, refer as appropriate. If information about child's pediatrician and/or medical conditions is on the WIC Medical Referral/Certification and/or the Medical Documentation (Rx) forms the parent brings to the appointment, verify and document health/clinical and medical risk factors. If **yes**/responded or selected— Select the appropriate medical condition on the Medical Conditions pop-up. This pop-up will automatically appear if **yes** is selected for this question. Selecting the medical condition in this pop-up will automatically populate as a risk factor on the Nutrition Risk screen.



CT-WIC Health Screen: Medical Conditions Pop-up

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.

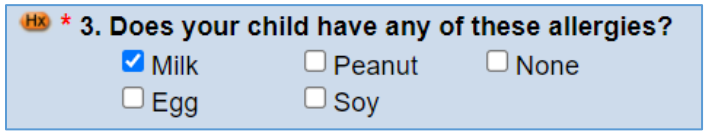
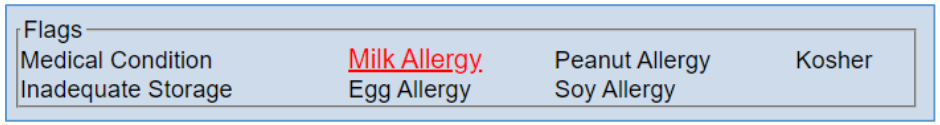
For new clients: Who is your child's doctor?
When was his/her last appointment?



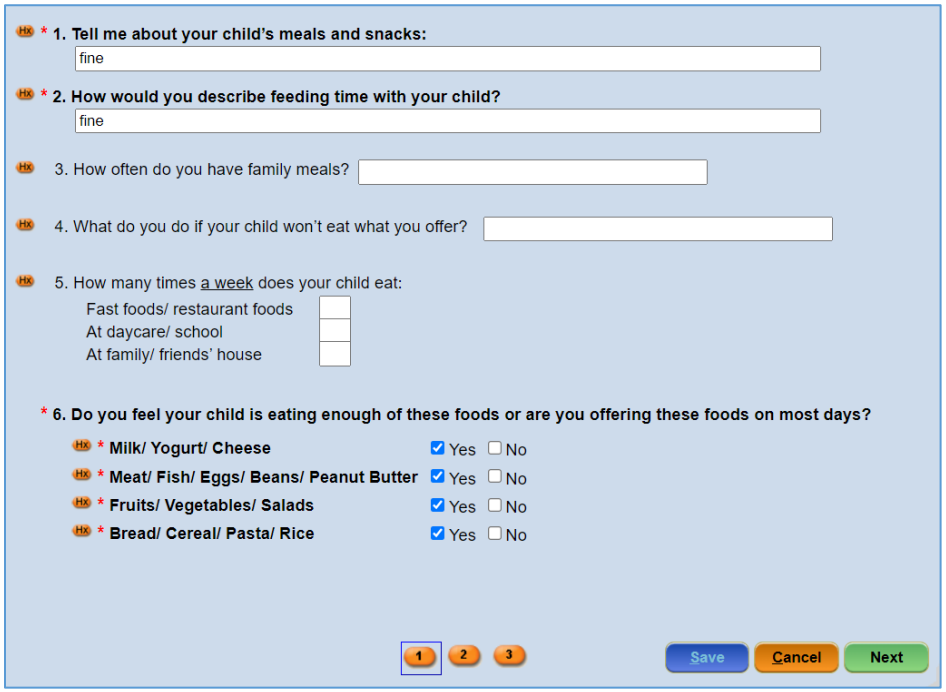
CT-WIC Participant Information Screen: Physician Name and Phone Field

The **Participant Information Screen** has a field that records medical provider information. Documenting a provider's information can be helpful to WIC staff for future appointments and counseling, especially when attempting to obtain anthropometric data or bloodwork results.

CT-WIC auto-assigns FNS Nutrition Risk Criterion #353 *Food Allergy* based on checked boxes. Use this information to provide appropriate counseling

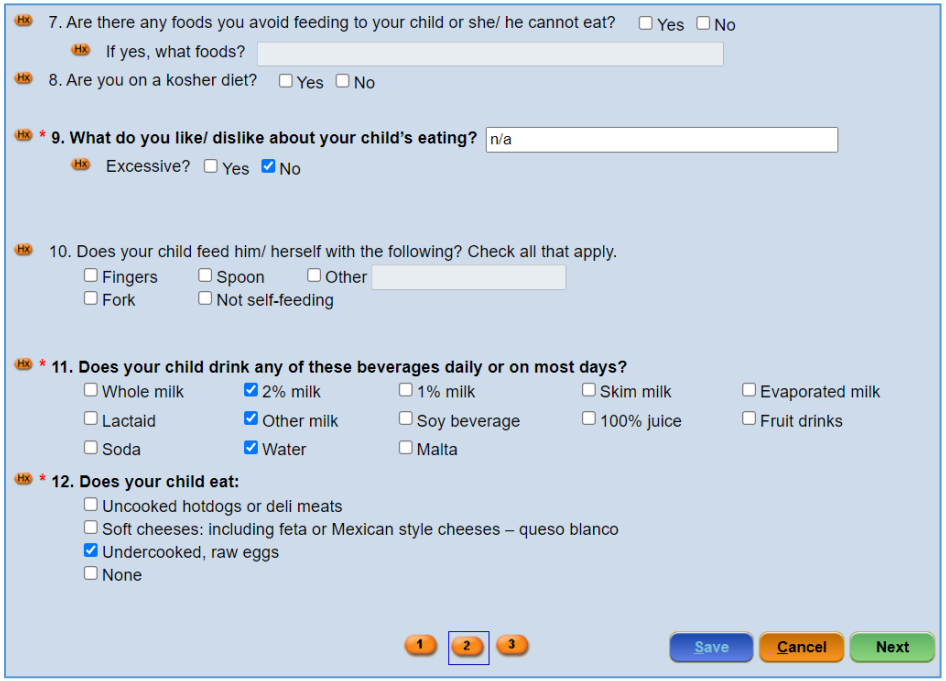
3. Does your child have any of these allergies? Milk Egg Soy Peanut None  **CT-WIC Health Screen: Q3**  **CT-WIC Food Prescription Screen: Allergy Indicator** **4. Does the child go for regular dental check-ups? Last visit?** Additional questions regarding dental care that you may ask. How often are your child's teeth brushed? Has your child been to the dentist? *For new clients:* Who is your child's dentist? **5. Does your child have any dental problems?** If yes, please describe.	and food package tailoring. Allergy FLAG will be RED on Food Prescription Screen. 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. General oral health guidelines: ▪ 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. The following questions/guidance can be asked/provided in conjunction with beverage/fluid questions in the diet-related section. ▪ Ask parent what, if anything, the child drinks to fall asleep. If a beverage is provided to child when he is falling asleep: 1. Ask what it is provided in (bottle, sippy cup) 2. Remind parent that, after brushing the teeth at night before bedtime, the only beverage that should be offered is plain water.
6. What medicines or supplements do you give your child? Check all that apply:	This question provides an opportunity to learn about various supplements, vitamins and medications is the parent/guardian is giving to their child. Vitamin D is a necessary dietary supplement per *AAP Clinical Report:*

Vitamins/Minerals Herbs Herbal Supplements Medications Other Why? 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*	*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. 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 more than 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. 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. Refer to 2020-2025 Dietary Guidelines Chapter 1, pg. 36 and Chapter 3, pg. 87 for recommendations on Vitamin D intake for Children.
7. Does your child regularly eat things that are not food? **Check all that apply:** Paper Dirt Pet Food Paint Chips Crayons Other	If **yes** selected, CT-WIC assigns FNS Nutrition Risk Criterion #425.9 *Compulsively ingesting non-food items (pica)*. Provide information/referrals as appropriate.

Household Smoking **8. In the past week, have you or your child been in an enclosed space where nicotine/tobacco was used?** 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, nicotine, drugs and alcohol. These can be sensitive questions to ask/answer so be aware and use cues from the participant when using probing questions. ▪ Ask about secondhand 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 and third hand smoke will stay on clothing and hand, and that all smokers should change clothes and wash hands prior to holding baby. ▪ 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) **Mealtimes and Places**  **CT-WIC Nutrition Screen, Page 1**	This series of questions/screens replace a food frequency/24 recall. The goal is to use these questions to engage the parent in conversation about their child's eating habits and mealtime behaviors. These questions do not all have to be discreetly answered by each parent, 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. Some general guidelines for mealtimes: ▪ Children thrive with structure in all areas of their lives. Regular feeding routines are an example of this. ▪ 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. ▪ 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. ▪ 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.* ▪ If the child is aware of the parent's specific food likes/dislikes, the child has too much information.

1. Tell me about your child's meals and snacks. **2. How would you describe feeding time with your child?** 3. How often do you have family meals? 4. What do you do, if your child won't eat what you've offered? 5. How many times a week does your child eat: Fast foods/restaurant foods At daycare/school At family/friends' house **6. Do you feel your child is eating enough of these foods or are you offering these foods on most days? Yes/No** Milk/Yogurt/Cheese Meat/Fish/Eggs/Beans/Peanut Butter/ Fruits/Vegetables/Salads Bread/Cereal/Pasta/Rice Other questions: How often does your child eat the same foods as the rest of the family?	▪ Because mealtime is also a social time, children eat better when they eat with others. ▪ Impose limits on unacceptable mealtime behavior without controlling amount of food child wants to eat. ▪ Use non-food items to reward or discipline child, such as stickers, trips to the playground, a new game, etc. ▪ 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. ▪ 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. ▪ Introduce new food in a neutral way. Talk about the color, shape, aroma and texture, but not how it tastes. ▪ Trying new foods takes time, so mealtimes should be relaxed but never prolonged. ▪ Well-balanced meals and snacks + Positive eating environment = Well-nourished child. Children need a pleasant, structured mealtime environment. ▪ Avoid letting child eat/drink in the car ▪ Pull highchair up to the table to include young toddler in family meal. Based on the information gathered, you may provide information/resources to address the parent/guardian's concerns, questions or identified barriers to positive health outcomes. Refer to the age-appropriate Nutrition Guide(s) found at https://connecticut.wicresources.org/

Nutrition Screen(s)
Foods, Drinks and Healthy Habit



CT-WIC Nutrition Screen, Page 2

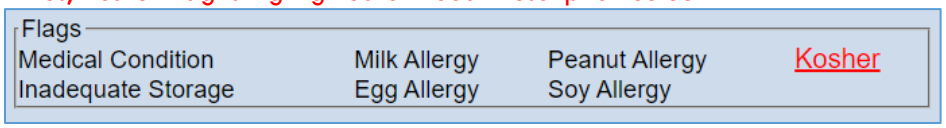
Some additional counseling tips/information to share with parents as appropriate based on feedback from asking these questions.

- 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.
- Because toddler growth is slowing down, appetites will naturally decrease. Preschoolers have an increased appetite and interest in foods.
- 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 they want to eat.

7. Are there any foods you avoid feeding to your child or he/she cannot eat? If yes, what foods?

- 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.

8. Is your child on a kosher diet? Yes/No
If Yes, Kosher flag is highlighted on Food Prescription Screen.



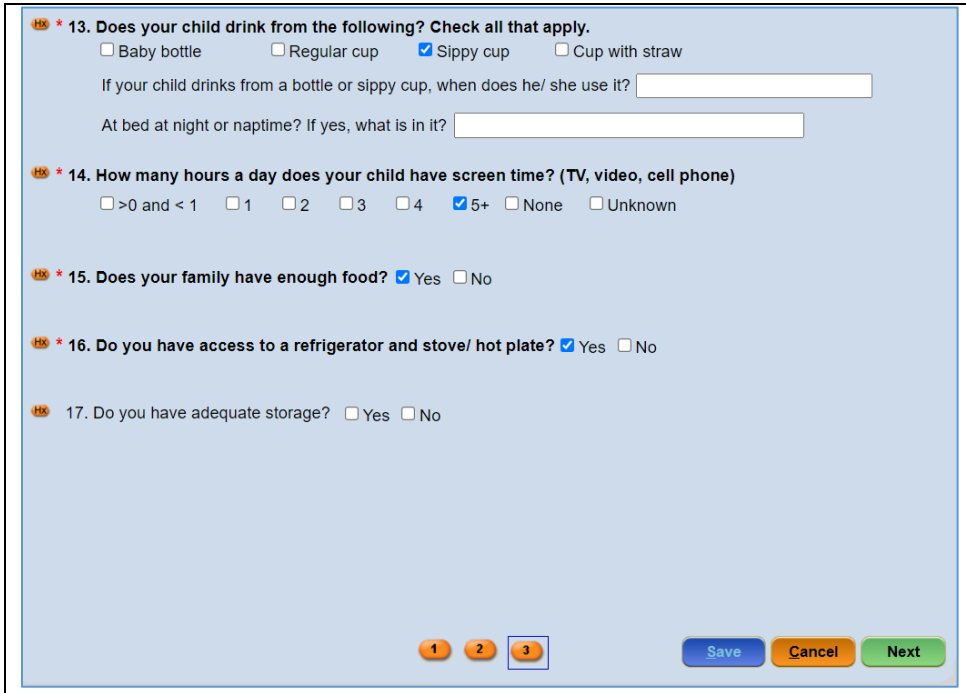
CT-WIC Food Prescription Screen: Kosher Indicator

9. What do you like/dislike about your child's eating?
Excessive? Yes/No

- Toddlers' bowel movements have no "normal" number or schedule, individual patterns depend on what they eat and drink, activity level, speed of digestion and removal of waste. Common reasons for constipation include:
  Eating too many low-fiber foods such as milk, cheese, yogurt, or peanut butter and not enough fruits, vegetables, and whole grains.
  Toilet anxiety or feeling pressured about toilet training, a child might start deliberately withholding stools. If they show all the signs of straining to have a bowel movement — stiffening their body, arching their back, and getting red in the face — but nothing comes out, they may be trying to hold it in. Even if a child is potty-trained, not taking enough

Optional additional questions not in CT-WIC: What are some foods you think your child eats too much of? If you could, what would you like to change about your child's eating habits? 10. Does your child feed themselves with the following? Check all that apply. Fingers Spoon Fork Other Not self-feeding **11. Does your child drink any of these beverages daily or on most days? Check all that apply.** (Variety of selections)	time on the toilet to completely empty their bowels 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. **Lack of activity.** Movement helps blood flow to your toddler's digestive system. **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. ▪ Refer parent who is concerned re: chronic constipation to the pediatrician. ▪ 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. ▪ **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. ▪ Refer to 2020-2025 Dietary Guidelines Chapter 2, pgs. 61-62 and Chapter 3, pgs. 87-88 for recommendations on beverage intake for Toddlers and Children. ▪ Refer the parent to the pediatrician if the child has diarrhea and doesn't seem to be improving after 24 hours. ▪ Also, advise the parent to call the pediatrician if the child has diarrhea and any of the following: -vomiting multiple times -signs of dehydration: such as dry mouth and infrequent urination (less than every six hours) -blood in his stool or black stool -a high fever-103 degrees Fahrenheit (39.4 degrees Celsius) or higher

12. Does your child eat: Uncooked hot dogs or deli meats Soft cheeses including feta or Mexican style cheeses- queso Blanco, Undercooked, raw eggs None	▪ *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. ▪ Make sure foods offered are healthy choices; avoid high sugar empty calorie foods. ▪ Remind parent not to struggle with child over food. ▪ 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. 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. Reminder to review choking hazard foods: ▪ Whole grapes, Raisins, Nuts & Seeds, Pretzels, Spoonful's of peanut butter, Raw carrots, other Dried fruit, and Popcorn ▪ Hard candy, Chips, Marshmallows, hot dog (coin cut)



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13. Does your child drink from the following? Check all that apply.

Baby bottle
Sippy cup
Regular cup
Cup with Straw

If your child drinks from bottle or Sippy cup, when does he/she use it?

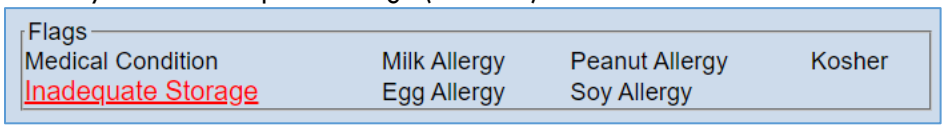
At bed at night or naptime? If yes, what is in it?

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.

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)?
>0 and <1,
1, 2, 3, 4, 5+ hours
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
WIC Works Resource System Fit WIC materials at:
https://wicworks.fns.usda.gov/wicworks//Sharing_Center/gallery/families.html

Food Security **15. Does your family have enough food?** **16. Do you have access to a refrigerator and stove/hot plate?** 17. Do you have adequate storage (for food)?  **CT-WIC Food Prescription Screen: Inadequate Storage Indicator**	This question allows the nutritionist to gauge household food security and provide appropriate referrals. If referrals are made, document in CT-WIC, Referrals Screen. If no, then Inadequate Storage FLAG is highlighted RED on Food Prescription Screen.