Nutrition Risk Criteria Handbook FFY 2013

Georgia WIC Program
Nutrition Unit

2 Peachtree Street NW
Atlanta Georgia, 30303
404-657-2884

Georgia Department of Public Health

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1. Risk 344 Thyroid Disorder: Corrected Hyper/hypo thyroidism definitions (pages 9, 26, 46)
2. Risk 115 High Weight for Length: Changed priority to III (page 79)
3. Risk 903 Foster Care: Changed priority to V (page 95)
4. Revised Appendixes to reflect changes for the birth to two year CDC WHO Growth Charts.
   a) Appendix J-1 and J-3 Remove "32 inch" reference (page 119 and 121)
   b) Appendix J-4 remove "stand unattended reference" (page 122)
   c) Appendixes K and L changed from "birth to 36 " growth charts to "Birth to 24" growth charts (page 123 and 127)

DATA AND DOCUMENTATION REQUIRED FOR WIC ASSESSMENT/CERTIFICATION

PRENATAL WOMEN

Data	Prenatal Women
Height	Required
Pre-Pregnancy Weight	Required
Current Weight	Required
Hematocrit or Hemoglobin	Required
Prenatal Weight Grid Plotted	Required
Evaluation of Inappropriate Nutrition Practices	Required
Risk Factor Assessment	Required

NUTRITION RISK CRITERIA
PREGNANT WOMEN

NOTE: High Risk Criteria, as defined below, are to be used for referral purposes, not certification (See Appendix A-1)

PREGNANT WOMEN		
CODE		**PRIORITY**
201	LOW HEMOGLOBIN/HEMATOCRIT Hemoglobin / Hematocrit 1st Trimester (0-13 wks): Non-Smokers: 10.9 gm or lower / 32.9% or lower Smokers: 11.2 gm or lower / 33.9% or lower 2nd Trimester (14-26 wks): Non-Smokers: 10.4 gm or lower / 31.9% or lower Smokers: 10.7 gm or lower / 32.9% or lower 3rd Trimester (27-40 wks): Non-Smokers: 10.9 gm or lower / 32.9% or lower Smokers: 11.2 gm or lower / 33.9% or lower **High Risk**: Hemoglobin **OR** hematocrit at treatment level (Appendix B-1)	I
101	UNDERWEIGHT Pre-pregnancy weight is equal to a Body Mass Index (BMI) of <18.5. Refer to BMI Table, Appendix C-1. **High Risk:** Pre-pregnancy BMI <18.5	**I**
111	OVERWEIGHT Pre-pregnancy weight is equal to a Body Mass Index of ≥25. Refer to BMI Table, Appendix C-1. **High Risk:** Pre-pregnancy BMI >29.9	**I**
131	LOW MATERNAL WEIGHT GAIN Low weight gain at any point in pregnancy, such that a pregnant women's weight plots at any point beneath the bottom line of the appropriate weight gain range for her respective prepregnancy weight category. Refer to Appendix C-2. **High Risk:** Low Maternal Weight Gain	**I**

PREGNANT WOMEN		
CODE		**PRIORITY**
132	GESTATIONAL WEIGHT LOSS DURING PREGNANCY • During **first** (0-13 weeks) trimester, any weight loss below pregravid weight; based on pregravid weight and current weight. **OR** • During **second** and **third** trimesters (14-40 weeks gestation), ≥2 lbs weight loss. Based on two weight measures recorded at 14 weeks gestation or later. **Document:** Two weight measures as specified above **High Risk:** Weight loss of ≥2 lbs in the second and third trimesters	**I**
133	HIGH MATERNAL WEIGHT GAIN High maternal weight gain at any point in pregnancy, such that a pregnant women's weight plots at any point above the top line of the appropriate weight gain range for her respective prepregnancy weight category.	**I**
211	ELEVATED BLOOD LEAD LEVELS Blood lead level of ≥10 μg/deciliter within the past 12 months. **Document:** Date of blood test and blood lead level in the participant's health record. Must be within the past 12 months. **High Risk:** Blood lead level of ≥10 μg/deciliter within the past 12 months.	**I**
301	HYPEREMESIS GRAVIDARUM Severe nausea and vomiting to the extent that the pregnant woman becomes dehydrated and acidotic. Presence of hyperemesis gravidarum diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record **High Risk:** Diagnosed hyperemesis gravidarum	**I**

PREGNANT WOMEN		
CODE		**PRIORITY**
302	GESTATIONAL DIABETES Gestational diabetes mellitus (GDM) is defined as any degree of glucose/carbohydrate intolerance with onset or first recognition during pregnancy. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed gestational diabetes	**I**
303	HISTORY OF GESTATIONAL DIABETES History of diagnosed gestational diabetes mellitus (GDM) Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record.	**I**
304	HISTORY OF Preeclampsia History of diagnosed preeclampsia Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders **Document:** Diagnosis and name of the physician that treated this condition in the participant's health record.	**I**
311	HISTORY OF PRETERM DELIVERY Any history of infant(s) born at 37 weeks gestation or less **Document:** Delivery date(s) and weeks gestation in participant's health record	**I**

PREGNANT WOMEN		
CODE		**PRIORITY**
312	HISTORY OF LOW BIRTH WEIGHT INFANT(S) Woman has delivered one (1) or more infants with a birth weight of less than or equal to 5 lb 8 oz (2500 gms). **Document:** Weight(s) and birth date(s) in the participant's health record	**I**
321	HISTORY OF FETAL OR NEONATAL DEATH Any fetal death(s) (death greater than or equal to 20 weeks gestation) or neonatal death(s) (death occurring from 0-28 days of life). **Document:** Date(s) of fetal/neonatal death(s) in the participant's health record; weeks gestation for fetal death(s); age, at death, of neonate(s). **This does not include elective abortions.**	**I**
331	PREGNANCY AT A YOUNG AGE For current pregnancy, EDC at less than 18 years and 10 months of age. **Document:** Expected date of delivery (EDC) on the WIC Assessment/ Certification Form **High Risk:** EDC at less than 17 years of age	**I**
332	CLOSELY SPACED PREGNANCIES For current pregnancy, the participant's EDC is less than 25 months after the termination of the last pregnancy. **Document:** Termination date of last pregnancy and EDC in the participant's health record	**I**

PREGNANT WOMEN		
CODE		**PRIORITY**
333	HIGH PARITY AND YOUNG AGE The following two (2) conditions must **both** apply: 1. The woman is under age 20 at date of conception, **AND** 2. She has had 3 or more **previous** pregnancies of at least 20 weeks duration, regardless of birth outcome. **Document:** EDC date; number of pertinent pregnancies (of at least 20 weeks gestation) and weeks gestation for each, in the participant's health record	**I**
334	LACK OF, OR INADEQUATE PRENATAL CARE Prenatal care beginning after the **1st trimester** (0-13 weeks) **Document:** Weeks gestation, in participant's health record, when prenatal care began. A pregnancy test is not prenatal care.	**I**
335	MULTI-FETAL GESTATION More than one (>1) fetus in a current pregnancy. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Multi-fetal gestation	**I**
336	FETAL GROWTH RESTRICTION Fetal Growth Restriction (FGR) (replaces the term Intrauterine Growth Retardation (IUGR)), may be diagnosed by a physician with serial measurements of fundal height, abdominal girth and can be confirmed with ultrasonography. FGR is usually defined as a fetal weight <10th percentile for gestational age. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. Fetal Growth Restriction (FGR) must be diagnosed by a physician or a health professional acting under standing orders of a physician. **Document:** Diagnosis in participant's health record **High Risk:** Fetal Growth Restriction	**I**

PREGNANT WOMEN		
CODE		**PRIORITY**
337	HISTORY OF BIRTH OF A LARGE FOR GESTATIONAL AGE INFANT Prenatal woman has delivered one (1) or more infants with a birth weight of 9 pounds (4000 gm) or more. **Document:** Birth weight(s) in the participant's health record	**I**
338	PREGNANT WOMAN CURRENTLY BREASTFEEDING Breastfeeding woman who is now pregnant. **Note:** Refer to or provide appropriate breastfeeding counseling, especially if at risk for not meeting her own nutrient needs, for a decrease in milk supply, or for premature labor.	**I**
339	HISTORY OF BIRTH WITH NUTRITION RELATED CONGENITAL OR BIRTH DEFECT(S) A prenatal woman with any history of giving birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid (neural tube defect), excess vitamin A (cleft palate or lip). **Document:** Infant(s) congenital and/or birth defect(s) in participant's health record	**I**

PREGNANT WOMEN	
CODE	**PRIORITY**
NUTRITION RELATED MEDICAL CONDITIONS	**I**
341 NUTRIENT DEFICIENCY DISEASES Diagnosis of clinical signs of nutritional deficiencies or a disease caused by insufficient dietary intake of macro or micronutrients. Diseases include, but not limited to: protein energy malnutrition, hypocalcemia, cheilosis, scurvy, osteomalacia, menkes disease, rickets, Vitamin K deficiency, xerothalmia, beriberi, and pellagra. (See Appendix D) The presence of nutrient deficiency diseases diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed nutrient deficiency disease	
342 GASTRO-INTESTINAL DISORDERS: Diseases or conditions that interfere with the intake, digestion, and or absorption of nutrients. The diseases and/or conditions include, but are not limited to: • Gastroesophageal reflux disease (GERD) • Peptic ulcer • Post-bariatric surgery • Short bowel syndrome • Inflammatory bowel disease, including ulcerative colitis or Crohn's disease • Liver disease • Pancreatitis • Biliary tract disease The presence of gastro-intestinal disorders as diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed gastro-intestinal disorder	**I**

PREGNANT WOMEN		
CODE		**PRIORITY**
343	DIABETES MELLITUS Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both. Presence of diabetes mellitus diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed diabetes mellitus	**I**
344	THYROID DISORDERS Thyroid dysfunctions that occur in pregnant and postpartum women, during fetal development, and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following: • Hyperthyroidism: Excessive thyroid hormone production (most commonly known as Graves' disease and toxic multinodular goiter). • Hyporthyroidism: Low secretion levels of thyroid hormone (can be overt or mild/subclinical). Most commonly seen as chronic autoimmune thyroiditis (Hashimoto's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed thyroid disorder	**I**
345	HYPERTENSION Presence of hypertension or prehypertension diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed hypertension	**I**

PREGNANT WOMEN		
CODE		**PRIORITY**
346	RENAL DISEASE Any renal disease including pyelonephritis and persistent proteinuria, but **EXCLUDING** urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self reported by applicant/ participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed renal disease	**I**
347	CANCER A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, **must** be severe enough to affect nutritional status. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Description of how the condition or treatment affects nutritional status and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed cancer	**I**
348	CENTRAL NERVOUS SYSTEM DISORDERS Conditions which affect energy requirements and may affect the individual's ability to feed self, that alter nutritional status metabolically, mechanically, or both. Includes, but is not limited to: epilepsy, cerebral palsy (CP), and neural tube defects (NTD) such as spina bifida and myelomeningocele. Presence of a central nervous system disorder(s) diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed central nervous system disorder	**I**

PREGNANT WOMEN		
CODE		**PRIORITY**
349	GENETIC AND CONGENITAL DISORDERS Hereditary or congenital condition at birth that causes physical or metabolic abnormality, or both. May include, but not limited to: cleft lip, cleft palate, thalassemia, sickle cell anemia, down's syndrome. Presence of genetic and congenital disorders diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed genetic/congenital disorder	**I**
351	INBORN ERRORS OF METABOLISM Gene mutations or gene deletions that alter metabolism in the body, including, but not limited to: phenylketonuria (PKU), maple syrup urine disease, galactosemia, hyperlipoproteinuria, homocystinuria, tyrosinemia, histidinemia, urea cycle disorder, glutaric aciduria, methylmalonic acidemia, glycogen storage disease, galactokinase deficiency, fructoaldase deficiency, propionic acidemia, hypermethioninemia. Presence of inborn errors of metabolism diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed inborn error of metabolism	**I**

PREGNANT WOMEN		
CODE		**PRIORITY**
352	INFECTIOUS DISEASES A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but is not limited to: tuberculosis, pneumonia, meningitis, parasitic infection, hepatitis, bronchiolitis (3 episodes in last 6 months), HIV/AIDS. The infectious disease **MUST** be present within the past 6 months and diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis, appropriate dates of each occurrence, and name of physician treating condition in the participant's health record. When using HIV/AIDS positive status as a Nutritionally Related Medical Condition, write "See Medical Record" for documentation purpose. **High Risk:** Diagnosed infectious disease, as described above	**I**
353	FOOD ALLERGIES An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed food allergy	**I**

PREGNANT WOMEN		
CODE		**PRIORITY**
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed Celiac Disease	**I**
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record; **OR** list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	**I**
356	HYPOGLYCEMIA Presence of hypoglycemia diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed hypoglycemia	**I**

PREGNANT WOMEN		
CODE		**PRIORITY**
357	DRUG/NUTRIENT INTERACTIONS Use of prescription or over the counter drugs or medications that have been shown to interfere with nutrient intake or utilization, to an extent that nutritional status is compromised. **Document:** Drug/medication being used and respective nutrient interaction in the participant's health record. **High Risk:** Use of drug or medication shown to interfere with nutrient intake or utilization, to extent that nutritional status is compromised.	**I**
358	EATING DISORDERS Eating disorders (anorexia nervosa and bulimia), are characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to: • Self-induced vomiting • Purgative abuse • Alternating periods of starvation • Use of drugs such as appetite suppressants, thyroid preparations or diuretics • Self-induced marked weight loss Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Symptoms or diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed eating disorder	**I**

PREGNANT WOMEN		
CODE		**PRIORITY**
359	RECENT MAJOR SURGERY, TRAUMA OR BURNS Major surgery (including C-sections), trauma or burns severe enough to compromise nutritional status. Any occurrence within the past 2 months may be self reported. Any occurrence more than 2 months previous **MUST** have the continued need for nutritional support diagnosed by a physician or health care provider working under the orders of a physician. **Document:** If occurred within the past 2 months, document surgery, trauma and/or burns in the participant's health record. If occurred more than 2 months ago, document description of how the surgery, trauma and/or burns currently affects nutritional status and include date. **High Risk:** Major surgery, trauma or burns that has a continued need for nutritional support.	**I**
360	OTHER MEDICAL CONDITIONS Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, **MUST** be severe enough to affect nutritional status. Including, but not limited to: juvenile rheumatoid arthritis (JRA), lupus erythematosus, cardiorespiratory diseases, heart disease, cystic fibrosis, moderate, Persistent Asthma (moderate or severe) requiring daily medication. Presence of medical condition(s) diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Specific medical condition; a description of how the disease, condition or treatment affects nutritional status and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed medical condition severe enough to compromise nutritional status	**I**
361	DEPRESSION Presence of depression diagnosed by a physician or psychologist as self reported by applicant/participant/caregiver; or as reported or documented by a physician, psychologist or health care provider working under the orders of a physician. **Document:** Diagnosis and name of physician that is treating this condition in the participant's health record	**I**

PREGNANT WOMEN		
CODE		**PRIORITY**
362	DEVELOPMENTAL, SENSORY OR MOTOR DELAYS INTERFERING WITH THE ABILITY TO EAT Developmental, sensory or motor delays include but are not limited to: minimal brain function, feeding problems due to developmental delays, birth injury, head trauma, brain damage, other disabilities. **Document:** Specific condition/ description of delays and how these interfere with the ability to eat and the name of the physician that is treating this condition. **High Risk:** Developmental, sensory or motor delay interfering with ability to eat.	I
371	MATERNAL SMOKING Any smoking of cigarettes, pipes or cigars. **Document:** Number of cigarettes or cigars smoked, or number of times pipe smoked, on WIC Assessment/Certification Form. See Appendix E-1 for documentation codes.	I
372	ALCOHOL AND ILLEGAL DRUG USE **Any alcohol use:** A serving of standard sized drink (1 ½ ounce of alcohol) is: • 1 can of beer (12 fluid oz) • 5 oz wine • 1 ½ fluid oz liquor Binge drinking is defined as ≥ 5 drinks on the same occasion on at least one day in the past 30 days Heavy drinking is defined as ≥ 5 drinks on the same occasion on five or more days in the past 30 days **Document:** Enter the number of servings of alcohol per week on the WIC Assessment/Certification Form. See Appendix E-1 for documentation codes.	I
	Any illegal drug use: **Document:** Type of drug(s) being used. See Appendix E-2 for commonly used illegal drug names.	

PREGNANT WOMEN		
CODE		**PRIORITY**
381	DENTAL PROBLEMS Diagnosis of dental problems by a physician or health care provider working under the orders of a physician or adequate documentation by the competent professional authority. Including but not limited to: gingivitis of pregnancy, tooth decay, periodontal disease, and tooth loss and/or ineffectively replaced teeth which impair the ability to ingest food in adequate quality or quantity. **Document:** In the participant's health record, a description of how the dental problem interferes with mastication and/or has other nutritionally related health problems.	**I**
400	INAPPROPRIATE NUTRITION PRACTICES Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. (Appendix G) **Document:** Inappropriate Nutrition Practice(s) in the participant's health record.	**IV**
401	FAILURE TO MEET DIETARY GUIDELINES A woman who meets eligibility requirements based on category, income, and residency but who does not have any other identified nutritional risk factor may be presumed to be at nutritional risk based on failure to meet the Dietary Guidelines for Americans. (This risk factor may be assigned only when a woman does not qualify for risk 400 or for any other risk factor.)	IV
502	TRANSFER OF CERTIFICATION Person with a current valid Verification of Certification (VOC) document from another state or local agency. The VOC is valid until the certification period expires, and shall be accepted as proof of eligibility for Program benefits. If the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all other waiting applicants. This criterion should be used primarily when the VOC card/document does not reflect another more specific nutrition risk condition at the time of transfer or if the participant was initially certified based on a nutrition risk condition not in use by the receiving agency.	**I, IV**

PREGNANT WOMEN		
CODE		**PRIORITY**
801	HOMELESSNESS Homelessness as defined in the Special Populations Section of the Georgia WIC Program Procedure Manual.	**IV**
802	MIGRANCY Migrancy as defined in the Special Populations Section of the Georgia WIC Program Procedures Manual.	**IV**
901	RECIPIENT OF ABUSE Battering (abuse) within past 6 months as self-reported, or as documented by a social worker, health care provider or on other appropriate documents, or as reported through consultation with a social worker, health care provider or other appropriate personnel. Battering refers to violent assaults on women.	**IV**
902	PRENATAL WOMAN WITH LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD Woman who is assessed to have limited ability to make appropriate feeding decisions and/or prepare food. Examples may include: • mental disability / delay and/or mental illness such as clinical depression (diagnosed by a physician or licensed psychologist) • physical disability which restricts or limits food preparation abilities • current use of or history of abusing alcohol or other drugs **Document:** The women's specific limited abilities in the participant's health record.	**IV**
903	Foster Care Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months.	**IV**
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside the home.	**I**

DATA AND DOCUMENTATION REQUIRED FOR WIC ASSESSMENT/CERTIFICATION

BREASTFEEDING WOMEN

Data	Breastfeeding and Non-Breastfeeding Woman Certified in Hospital Prior to Initial Discharge	Woman Certified in Clinic	Breastfeeding Woman Mid-Assessment
Height	Pre-pregnancy height from health record; self reported if not available from record	Required	Required
Pre-Pregnancy Weight	Pre-pregnancy weight from health record; self reported if not available from record	Required	Required
Current Weight	If available	Required	Required
Last Weight Before Delivery	Required	Required	Required
Hemoglobin or Hematocrit	Required (Apply 90-day rule when not available)	Required	Optional
Evaluation of Inappropriate Nutrition Practices	Required	Required	Required
Risk Factor Assessment	Required	Required	Required

NUTRITION RISK CRITERIA
BREASTFEEDING WOMEN

NOTE: High Risk Criteria, as defined below, are to be used for referral purposes, not certification (See Appendix A-1)

BREASTFEEDING WOMEN				
CODE				**PRIORITY**
201	LOW HEMOGLOBIN/HEMATOCRIT			**I**
	Non-Smokers:	Hemoglobin:	11.9 gm or lower (≥ 15 years of age) 11.7 gm or lower (< 15 years of age)	
		Hematocrit:	35.8% or lower	
	Smokers:	Hemoglobin:	12.2 gm or lower (≥ 15 years of age) 12.0 gm or lower (< 15 years of age)	
		Hematocrit:	36.8% or lower	
	High Risk: Hemoglobin **OR** hematocrit at treatment level (Appendix B-1)			
101	UNDERWEIGHT			**I**
	< 6 months Postpartum: Pre-pregnancy **or current** weight is equal to a Body Mass Index (BMI) of <18.5. Refer to BMI Table, Appendix C-1.			
	≥ 6 months Postpartum: Current weight is equal to a Body Mass Index (BMI) of <18.5. Refer to BMI Table, Appendix C-1.			
	High Risk: Current BMI <18.5			
111	OVERWEIGHT			**I**
	<6 months Postpartum: Pre-pregnancy weight is equal to a Body Mass Index (BMI) of ≥25. Refer to BMI Table, Appendix C-1.			
	≥ 6 months Postpartum: Current weight is equal to a Body Mass Index (BMI) of ≥25. Refer to BMI Table, Appendix C-1.			
	High Risk: Current BMI >29.9			

BREASTFEEDING WOMEN

CODE		PRIORITY
133	HIGH MATERNAL WEIGHT GAIN Breastfeeding (most recent pregnancy only): total gestational weight gain exceeding the upper limit of the recommended range based on Body Mass Index (BMI), as follows: **Prepregnancy Weight Group** / **Definition (BMI)** / **Cut-off Value (Singleton)** / **Cut-off Value (Multi-Fetal)** Underweight / < 18.5 / >40 lbs / * Normal Weight / 18.5 to 24.9 / >35 lbs / >54 lbs Overweight / 25.0 to 29.9 / >25 lbs / >50 lbs Obese / ≥ 30.0 / >20 lbs / >42 lbs *There are no provisional guidelines for underweight woman with multiple fetuses. (Appendix C-2) **Document:** Pre-gravid weight and last weight before delivery	I
211	ELEVATED BLOOD LEAD LEVELS Blood lead level of ≥10 μg/deciliter within the past 12 months. **Document:** Date of blood test and blood lead level in the participant's health record. Must be within the past 12 months. **High Risk:** Blood lead level of ≥10 μg/deciliter within the past 12 months.	I
303	HISTORY OF GESTATIONAL DIABETES History of diagnosed gestational diabetes mellitus (GDM) Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders for any pregnancy. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record.	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
304	HISTORY OF PREECLAMPSIA History of diagnosed preeclampsia Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders for any pregnancy. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record.	I
311	DELIVERY OF PREMATURE INFANT(S) Woman has delivered one (1) or more infants at 37 weeks gestation or less. **Applies to most recent pregnancy only.** **Document**: Delivery date and weeks gestation in participant's health record	I
312	DELIVERY OF LOW BIRTH WEIGHT INFANT(S) Woman has delivered one (1) or more infants with a birth weight of less than or equal to 5 lb 8 oz (2500 gms). **Applies to most recent pregnancy only.** **Document:** Weight(s) and birth date in the participant's health record	I
321	FETAL OR NEONATAL DEATH A fetal death (death ≥ 20 weeks gestation) or a neonatal death (death occurring from 0-28 days of life). **Applies to most recent pregnancy only.** **Document:** Date(s) of fetal/neonatal death(s) in the participant's health record; weeks gestation for fetal death(s); age, at death, of neonate(s). **This does not include elective abortions.**	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
331	PREGNANCY AT A YOUNG AGE For most recent pregnancy, delivery date at less than 18 years and 10 months of age. **Applies to most recent pregnancy only.** **Document:** Delivery date on the WIC Assessment/Certification Form **High Risk:** Delivery date at less than 17 years of age	I
332	CLOSELY SPACED PREGNANCIES Delivery date for most recent pregnancy occurred less than 25 months after the termination of the previous pregnancy. **Document:** Termination dates of last two pregnancies in the participant's health record.	I
333	HIGH PARITY AND YOUNG AGE The following two (2) conditions must both apply: 1. The woman is under age 20 at date of conception **AND** 2. She has had 3 or more pregnancies of at least 20 weeks duration (regardless of birth outcome), previous to the most recent pregnancy. **Document:** Delivery date; number of pertinent previous pregnancies (of at least 20 weeks gestation) and weeks gestation for each, in the participant's health record.	I
335	MULTI FETAL GESTATION More than one (>1) fetus in the most recent pregnancy **High Risk:** Multi-fetal gestation	I
337	HISTORY OF A LARGE FOR GESTATIONAL AGE INFANT Most recent pregnancy, or history of giving birth to an infant with a birth weight of 9 pounds or more. **Document:** Birth weight(s) and date(s) of deliveries in the participant's health record.	I

BREASTFEEDING WOMEN		
CODE		**PRIORITY**
339	BIRTH WITH NUTRITION RELATED CONGENITAL OR BIRTH DEFECT(S) A woman who gives birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid (neural tube defect), excess vitamin A (cleft palate or lip). **Applies to most recent pregnancy only.** **Document:** Infant(s) congenital and/or birth defect(s) in participant's health record	**I**
NUTRITION RELATED MEDICAL CONDITIONS		**I**
341	NUTRIENT DEFICIENCY DISEASES Diagnosis of clinical signs of nutritional deficiencies or a disease caused by insufficient dietary intake of macro or micro nutrients. Diseases include, but not limited to: protein energy malnutrition, hypocalcemia, cheilosis, scurvy, osteomalacia, menkes disease, rickets, Vitamin K deficiency, xerothalmia, beriberi, and pellagra. (See Appendix D) The presence of nutrient deficiency diseases diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in participant's health record. **High Risk:** Diagnosed nutrient deficiency disease	

BREASTFEEDING WOMEN		
CODE		PRIORITY
342	GASTRO-INTESTINAL DISORDERS Diseases or conditions that interfere with the intake, digestion, and or absorption of nutrients. The diseases and/or conditions include, but are not limited to: • Gastroesophageal reflux disease (GERD) • Peptic ulcer • Post-bariatric surgery • Short bowel syndrome • Inflammatory bowel disease, including ulcerative colitis or Crohn's disease • Liver disease • Pancreatitis • Biliary tract disease The presence of gastro-intestinal disorders as diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed gastro-intestinal disorder	I
343	DIABETES MELLITUS Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both. Presence of diabetes mellitus diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed diabetes mellitus	I

BREASTFEEDING WOMEN		
CODE		PRIORITY
344	THYROID DISORDERS Thyroid dysfunctions that occur in pregnant and postpartum women, during fetal development, and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following: • Hyperthyroidism: Excessive thyroid hormone production (most commonly known as Graves' disease and toxic multinodular goiter). • Hypothyroidism: Low secretion levels of thyroid hormone (can be overt or mild/subclinical). Most commonly seen as chronic autoimmune thyroiditis (Hashimoto's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency. • Postpartum Thyroiditis: Transient or permanent thyroid dysfunction occurring in the first year after delivery based on an autoimmune inflammation of the thyroid. Frequently, the resolution is spontaneous. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk: Diagnosed thyroid disorder**	I
345	HYPERTENSION Presence of hypertension or prehypertension diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed hypertension	I
346	RENAL DISEASE Any renal disease including pyelonephritis and persistent proteinuria, but **EXCLUDING** urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self reported by applicant/ participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in participant's health record. **High Risk:** Diagnosed renal disease	I

BREASTFEEDING WOMEN		
CODE		**PRIORITY**
347	CANCER A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, **must** be severe enough to affect nutritional status. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Description of how the condition or treatment affects nutritional status and the name of the physician that is treating the condition in the participant's health record. **High Risk:** Diagnosed cancer	**I**
348	CENTRAL NERVOUS SYSTEM DISORDERS Conditions which affect energy requirements and may affect the individual's ability to feed self that alter nutritional status metabolically, mechanically, or both. Includes, but is not limited to: epilepsy, cerebral palsy (CP), and neural tube defects (NTD) such as spina bifida and myelomeningocele. Presence of a central nervous system disorder(s) diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in participant's health record. **High Risk:** Diagnosed central nervous system disorder	**I**

BREASTFEEDING WOMEN		
CODE		**PRIORITY**
349	GENETIC AND CONGENITAL DISORDERS Hereditary or congenital condition at birth that causes physical or metabolic abnormality, or both. May include, but not limited to: cleft lip, cleft palate, thalassemia, sickle cell anemia, down's syndrome. Presence of genetic and congenital disorders diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in participant's health record. **High Risk:** Diagnosed genetic/congenital disorder	**I**
351	INBORN ERRORS OF METABOLISM Gene mutations or gene deletions that alter metabolism in the body, including, but not limited to: phenylketonuria (PKU), maple syrup urine disease, galactosemia, hyperlipoproteinuria, homocystinuria, tyrosinemia, histidinemia, urea cycle disorder, glutaric aciduria, methylmalonic acidemia, glycogen storage disease, galactokinase deficiency, fructoaldase deficiency, propionic acidemia, hypermethioninemia. Presence of inborn errors of metabolism diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in participant's health record. **High Risk:** Diagnosed inborn error of metabolism	**I**

BREASTFEEDING WOMEN		
CODE		PRIORITY
352	INFECTIOUS DISEASES A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but is not limited to: tuberculosis, pneumonia, meningitis, parasitic infection, hepatitis, bronchiolitis (3 episodes in last 6 months), HIV/AIDS. The infectious disease **MUST** be present within the past 6 months and diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis, appropriate dates of each occurrence, and name of physician treating this condition in the participant's health record. When using HIV/AIDS positive status as a Nutritionally Related Medical Condition, write "See Medical Record" for documentation purpose. **High Risk:** Diagnosed infectious disease, as described above	**I**
353	FOOD ALLERGIES An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and name of the physician that is treating this condition in participant's health record. **High Risk:** Diagnosed food allergy	**I**

BREASTFEEDING WOMEN		
CODE		PRIORITY
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and name of the physician that is treating this condition in participant's health record. **High Risk:** Diagnosed Celiac Disease	I
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record; **OR** list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	I

BREASTFEEDING WOMEN		
CODE		**PRIORITY**
356	HYPOGLYCEMIA Presence of hypoglycemia diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed hypoglycemia	**I**
357	DRUG/NUTRIENT INTERACTIONS Use of prescription or over the counter drugs or medications that have been shown to interfere with nutrient intake or utilization, to an extent that nutritional status is compromised. **Document:** Drug/medication being used and respective nutrient interaction in the participant's health record. **High Risk:** Use of drug or medication shown to interfere with nutrient intake or utilization, to extent that nutritional status is compromised.	**I**

BREASTFEEDING WOMEN		
CODE		**PRIORITY**
358	EATING DISORDERS Eating disorders (anorexia nervosa and bulimia), are characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to: • Self-induced vomiting • Purgative abuse • Alternating periods of starvation • Use of drugs such as appetite suppressants, thyroid preparations or diuretics • Self-induced marked weight loss Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Symptoms or diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed eating disorder	**I**
359	RECENT MAJOR SURGERY, TRAUMA OR BURNS Major surgery (including C-sections), trauma or burns severe enough to compromise nutritional status. Any occurrence within the past 2 months may be self reported. Any occurrence more than 2 months previous **MUST** have the continued need for nutritional support diagnosed by a physician or health professional acting under the standing orders of a physician. **Document:** If occurred within the past 2 months, document surgery, trauma and/or burns in the participant's health record. If occurred more than 2 months ago, document description of how the surgery, trauma and/or burns currently affects nutritional status and include date. **High Risk:** Major surgery, trauma or burns that has a continued need for nutritional support.	**I**

BREASTFEEDING WOMEN		
CODE		**PRIORITY**
360	OTHER MEDICAL CONDITIONS Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, **MUST** be severe enough to affect nutritional status. Including, but not limited to: juvenile rheumatoid arthritis (JRA), lupus erythematosus, cardiorespiratory diseases, heart disease, cystic fibrosis, moderate, Persistent Asthma (moderate or severe) requiring daily medication. Presence of medical condition(s) diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Specific medical condition; a description of how the disease, condition or treatment affects nutritional status and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed medical condition severe enough to compromise nutritional status	**I**
361	DEPRESSION Presence of depression diagnosed by a physician or psychologist as self reported by applicant/participant/caregiver; or as reported or documented by a physician, psychologist or health care provider working under the orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in participant's health record.	**I**

BREASTFEEDING WOMEN		
CODE		**PRIORITY**
362	DEVELOPMENTAL, SENSORY OR MOTOR DELAYS INTERFERING WITH ABILITY TO EAT Developmental, sensory or motor delays include but are not limited to: minimal brain function, feeding problems due to developmental delays, birth injury, head trauma, brain damage, other disabilities. **Document:** Specific condition/description of the delay and how it interferes with the ability to eat and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Developmental, sensory or motor delay interfering with ability to eat.	**I**
363	PRE-DIABETES Presence of pre-diabetes diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed pre-diabetes	**I**
371	MATERNAL SMOKING Any smoking of cigarettes, pipes or cigars. **Document:** Number of cigarettes or cigars smoked, or number of times pipe smoked, on WIC Assessment/Certification Form.	**I**

BREASTFEEDING WOMEN		
CODE		**PRIORITY**
372	ALCOHOL AND ILLEGAL DRUG USE **Alcohol use:** • Routine current use of ≥ 2 drinks per day **OR** • Binge drinking is defined as ≥5 drinks on the same occasion on at least one day in the past 30 days, **OR** • Heavy drinking is defined as ≥5 drinks on the same occasion on five or more days in the past 30 days A serving of standard sized drink (1 ½ ounce of alcohol) is: - 1 can of beer (12 fluid oz) - 5 oz wine - 1 ½ fluid oz liquor **Document:** Alcohol Use; identify type (Routine - Enter oz./wk: ___, Binge drinker, Heavy drinker) on WIC Assessment/Certification Form. See Appendix E-1 for documentation codes.	**I**
	Any Illegal drug use: **Document:** Type of drug(s) being used. See Appendix E-2 for commonly used illegal drug names.	
381	DENTAL PROBLEMS Diagnosis of dental problems by a physician or health care provider working under the orders of a physician or adequate documentation by the competent professional authority. Including but not limited to: tooth decay, periodontal disease, and tooth loss and/or ineffectively replaced teeth which impair the ability to ingest food in adequate quality or quantity. **Document:** In the participant's health record, a description of how the dental problem interferes with mastication and/or has other nutritionally related health problems.	**I**

BREASTFEEDING WOMEN		
CODE		**PRIORITY**
400	INAPPROPRIATE NUTRITION PRACTICES Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. (Appendix G) **Document:** Inappropriate Nutrition Practice(s) in the participant's health record.	**IV**
401	FAILURE TO MEET DIETARY GUIDELINES A woman who meets eligibility requirements based on category, income, and residency but who does not have any other identified nutritional risk factor may be **presumed** to be at nutritional risk based on failure to meet the *Dietary Guidelines for Americans*. **(This risk factor may be assigned only when a woman does not qualify for risk 400 or for any other risk factor.)**	**IV**
502	TRANSFER OF CERTIFICATION Person with a current valid Verification of Certification (VOC) document from another state or local agency. The VOC is valid until the certification period expires, and shall be accepted as proof of eligibility for Program benefits. If the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all other waiting applicants. This criterion should be used primarily when the VOC card/document does not reflect another more specific nutrition risk condition at the time of transfer or if the participant was initially certified based on a nutrition risk condition not in use by the receiving agency.	**I, II, IV**
601	BREASTFEEDING AN INFANT AT NUTRITIONAL RISK A breastfeeding woman whose breastfed infant has been determined to be at nutritional risk. **Document:** Infant's risks on mother's WIC Assessment/Certification Form.	**I, II, IV**

BREASTFEEDING WOMEN		
CODE		**PRIORITY**
602	BREASTFEEDING COMPLICATIONS OR POTENTIAL COMPLICATIONS A breastfeeding woman with any of the following complications or potential complications for breastfeeding. a. severe breast engorgement b. recurrent plugged ducts c. mastitis d. flat or inverted nipples e. cracked, bleeding or severely sore nipples f. age ≥ 40 years g. failure of milk to come in by 4 days postpartum h. tandem nursing (nursing two siblings who are not twins) **Document:** Complications or potential complications in the participant's health record. **High Risk:** Refer to or provide the mother with appropriate breastfeeding counseling.	**I**
801	HOMELESSNESS Homelessness as defined in the Special Populations Section of the Georgia WIC Program Procedures Manual.	**IV**
802	MIGRANCY Migrancy as defined in the Special Population Section of the Georgia WIC Program Procedures Manual.	**IV**
901	RECIPIENT OF ABUSE Battering within past 6 months as self-reported, or as documented by a social worker, health care provider or on other appropriate documents, or as reported through consultation with a social worker, health care provider or other appropriate personnel. Battering refers to violent assaults on women.	**IV**

BREASTFEEDING WOMEN		
CODE		**PRIORITY**
902	BREASTFEEDING WOMAN WITH LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD Woman who is assessed to have limited ability to make appropriate feeding decisions and/or prepare food. Examples may include: • mental disability / delay and/or mental illness such as clinical depression (diagnosed by a physician or licensed psychologist) • physical disability which restricts or limits food preparation abilities • current use of or history of abusing alcohol or other drugs **Document:** The women's specific limited abilities in the participant's health record.	**IV**
903	Foster Care Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months.	**IV**
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside the home.	**I**

DATA AND DOCUMENTATION REQUIRED FOR WIC ASSESSMENT/CERTIFICATION

POSTPARTUM NON-BREASTFEEDING WOMEN

Data	Woman Certified in Hospital Prior to Initial Discharge	Woman Certified in Clinic
Height	Pre-pregnancy height from health record; self reported if not available from record	Required
Pre-Pregnancy Weight	Pre-pregnancy weight from health record; self reported if not available from record	Required
Current Weight	If available	Required
Last Weight Before Delivery	Required	Required
Hemoglobin or Hematocrit	Required (Apply 90-day rule when not available)	Required
Evaluation of Inappropriate Nutrition Practices	Required	Required
Risk Factor Assessment	Required	Required

NUTRITION RISK CRITERIA
POSTPARTUM, NON- BREASTFEEDING WOMEN

NOTE: High Risk Criteria, as defined below, are to be used for referral purposes, not certification (See Appendix A-1)

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
201	LOW HEMOGLOBIN/HEMATOCRIT Non-Smokers: Hemoglobin: 11.9 gm or lower (≥ 15 years of age); 11.7 gm or lower (< 15 years of age) Hematocrit: 35.8% or lower Smokers: Hemoglobin: 12.2 gm or lower (≥ 15 years of age); 12.0 gm or lower (< 15 years of age) Hematocrit: 36.8% or lower **High Risk**: Hemoglobin **OR** hematocrit at treatment level (Appendix B-1)	**VI**
101	UNDERWEIGHT Pre-pregnancy **or current** weight is equal to a Body Mass Index (BMI) of <18.5. Refer to BMI Table, Appendix C-1. **High Risk:** Pre-pregnancy **or current** BMI <18.5	**VI**
111	OVERWEIGHT Pre-pregnancy weight is equal to a Body Mass Index (BMI) of ≥25. Refer to BMI Table, Appendix C-1. **High Risk:** Pre-pregnancy BMI >29.9	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN

CODE		PRIORITY
133	HIGH MATERNAL WEIGHT GAIN Non-Breastfeeding (most recent pregnancy only): total gestational weight gain exceeding the upper limit of the recommended range based on Body Mass Index (BMI), as follows: **Prepregnancy Weight Group** / **Definition (BMI)** / **Cut-off Value (Singleton)** / **Cut-off Value (Multi-Fetal)** Underweight / < 18.5 / >40 lbs / * Normal Weight / 18.5 to 24.9 / >35 lbs / >54 lbs Overweight / 25.0 to 29.9 / >25 lbs / >50 lbs Obese / ≥ 30.0 / >20 lbs / >42 lbs *There are no provisional guidelines for underweight woman with multiple fetuses. (Appendix C-2) **Document:** Pre-gravid weight and last weight before delivery	**VI**
211	ELEVATED BLOOD LEAD LEVELS Blood lead level of ≥10 μg/deciliter within the past 12 months. **Document:** Date of blood test and blood lead level in the participant's health record. Must be within the past 12 months. **High Risk:** Blood lead level of ≥10 μg/deciliter within the past 12 months.	**VI**
303	HISTORY OF GESTATIONAL DIABETES History of diagnosed gestational diabetes mellitus (GDM) Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders for any pregnancy. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record.	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
304	HISTORY OF PREECLAMPSIA History of diagnosed preeclampsia Presence of condition diagnosed by a physician as self-reported by applicant/participant/caregiver; or as reported or documented by physician, or someone working under physician's orders for any pregnancy. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record.	**VI**
311	DELIVERY OF PREMATURE INFANT(S) Woman has delivered one (1) or more infants at 37 weeks gestation or less. **Applies to most recent pregnancy only.** **Document**: Delivery date and weeks gestation in participant's health record	**VI**
312	DELIVERY OF LOW BIRTH WEIGHT INFANT(S) Woman has delivered one (1) or more infants with a birth weight of less than or equal to 5 lb 8 oz (2500 gms). **Applies to most recent pregnancy only.** **Document:** Weight(s) and birth date in the participant's health record.	**VI**
321	FETAL OR NEONATAL DEATH A fetal death (death ≥ 20 weeks gestation) or a neonatal death (death occurring from 0-28 days of life). **Applies to most recent pregnancy only.** **Document:** Date(s) of fetal/neonatal death(s) in the participant's health record; weeks gestation for fetal death(s); age, at death, of neonate(s). **This does not include elective abortions.**	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
331	PREGNANCY AT A YOUNG AGE For most recent pregnancy, delivery date at less than 18 years and 10 months of age. **Applies to most recent pregnancy only.** **Document:** Delivery date on the WIC Assessment/Certification Form **High Risk:** Delivery date at less than 17 years of age	**III**
332	CLOSELY SPACED PREGNANCIES Delivery date for most recent pregnancy occurred less than 25 months after the termination of the previous pregnancy. **Document:** Termination dates of last two pregnancies in the participant's health record.	**VI**
333	HIGH PARITY AND YOUNG AGE The following two (2) conditions must both apply: 1. The woman is under age 20 at date of conception **AND** 2. She has had 3 or more pregnancies of at least 20 weeks duration (regardless of birth outcome), previous to the most recent pregnancy. **Document:** Delivery date; number of pertinent previous pregnancies (of at least 20 weeks gestation) and weeks gestation for each, in the participant's health record	**VI**
335	MULTI FETAL GESTATION More than one (>1) fetus in the **most recent pregnancy** **High Risk:** Multi-fetal gestation	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**CODE**
337	HISTORY OF A LARGE FOR GESTATIONAL AGE INFANT Most recent pregnancy, or history of giving birth to an infant with a birth weight of 9 pounds or more. **Document:** Birth weight(s) and date(s) of deliveries in the participant's health record.	**VI**
339	BIRTH WITH NUTRITION RELATED CONGENITAL OR BIRTH DEFECT(S) A woman who gives birth to an infant who has a congenital or birth defect linked to inappropriate nutritional intake, e.g., inadequate zinc, folic acid (neural tube defect) , excess vitamin A (cleft palate or lip). **Applies to most recent pregnancy only.** **Document:** Infant(s) congenital and/or birth defect(s) in the participant's health record.	**VI**
NUTRITION RELATED MEDICAL CONDITIONS		**VI**
341	NUTRIENT DEFICIENCY DISEASES Diagnosis of clinical signs of nutritional deficiencies or a disease caused by insufficient dietary intake of macro or micro nutrients. Diseases include, but not limited to: protein energy malnutrition, hypocalcemia, cheilosis, scurvy, osteomalacia, menkes disease, rickets, Vitamin K deficiency, xerothalmia, beriberi, and pellagra. (See Appendix D) The presence of nutrient deficiency diseases diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in participant's health record. **High Risk:** Diagnosed nutrient deficiency disease	

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
342	GASTRO-INTESTINAL DISORDERS Diseases or conditions that interfere with the intake, digestion, and or absorption of nutrients. The diseases and/or conditions include, but are not limited to: • Gastroesophageal reflux disease (GERD) • Peptic ulcer • Post-bariatric surgery • Short bowel syndrome • Inflammatory bowel disease, including ulcerative colitis or Crohn's disease • Liver disease • Pancreatitis • Biliary tract disease The presence of gastro-intestinal disorders as diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed gastro-intestinal disorder	**VI**
343	DIABETES MELLITUS Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both. Presence of diabetes mellitus diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed diabetes mellitus	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
344	THYROID DISORDERS Thyroid dysfunctions that occur in pregnant and postpartum women, during fetal development, and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following: • Hyperthyroidism: Excessive thyroid hormone production (most commonly known as Graves' disease and toxic multinodular goiter). • Hyporthyroidism: Low secretion levels of thyroid hormone (can be overt or mild/subclinical). Most commonly seen as chronic autoimmune thyroiditis (Hashimoto's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency. • Postpartum Thyroiditis: Transient or permanent thyroid dysfunction occurring in the first year after delivery based on an autoimmune inflammation of the thyroid. Frequently, the resolution is spontaneous. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed thyroid disorder	**VI**
345	HYPERTENSION Presence of hypertension or prehypertension diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed hypertension	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
346	RENAL DISEASE Any renal disease including pyelonephritis and persistent proteinuria, but **EXCLUDING** urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in participant's health record. **High Risk:** Diagnosed renal disease	**VI**
347	CANCER A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, **must** be severe enough to affect nutritional status. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Description of how the condition or treatment affects nutritional status and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed cancer	**VI**
348	CENTRAL NERVOUS SYSTEM DISORDERS Conditions which affect energy requirements and may affect the individual's ability to feed self, that alter nutritional status metabolically, mechanically, or both. Includes, but is not limited to: epilepsy, cerebral palsy (CP), and neural tube defects (NTD) such as spina bifida and myelomeningocele. Presence of central nervous system disorder(s) diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in participant's health record. **High Risk:** Diagnosed central nervous system disorder	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
349	GENETIC AND CONGENITAL DISORDERS Hereditary or congenital condition at birth that causes physical or metabolic abnormality, or both. May include, but not limited to: cleft lip, cleft palate, thalassemia, sickle cell anemia, down's syndrome. Presence of genetic and congenital disorders diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in participant's health record. **High Risk:** Diagnosed genetic/congenital disorder	**VI**
351	INBORN ERRORS OF METABOLISM Gene mutations or gene deletions that alter metabolism in the body, including, but not limited to: phenylketonuria (PKU), maple syrup urine disease, galactosemia, hyperlipoproteinuria, homocystinuria, tyrosinemia, histidinemia, urea cycle disorder, glutaric aciduria, methylmalonic acidemia, glycogen storage disease, galactokinase deficiency, fructoaldase deficiency, propionic acidemia, hypermethionninemia. Presence of inborn errors of metabolism diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in participant's health record. **High Risk:** Diagnosed inborn error of metabolism	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
352	INFECTIOUS DISEASES A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but is not limited to: tuberculosis, pneumonia, meningitis, parasitic infection, hepatitis, bronchiolitis (3 episodes in last 6 months), HIV/AIDS. The infectious disease **MUST** be present within the past 6 months and diagnosed by a physician as self reported by applicant/participant/ caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis, appropriate dates of each occurrence, and name of physician treating condition in the participant's health record. When using HIV/AIDS positive status as a Nutritionally Related Medical Condition, write "See Medical Record" for documentation purpose. **High Risk:** Diagnosed infectious disease, as described above	**VI**
353	FOOD ALLERGIES An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and the name of the physician that is treating this condition. **High Risk:** Diagnosed food allergy	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and the name of the physician that is treating this condition. **High Risk:** Diagnosed Celiac Disease	**VI**
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record; **OR** list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
356	HYPOGLYCEMIA Presence of hypoglycemia diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed hypoglycemia	**VI**
357	DRUG/NUTRIENT INTERACTIONS Use of prescription or over the counter drugs or medications that have been shown to interfere with nutrient intake or utilization, to an extent that nutritional status is compromised. **Document:** Drug/medication being used and respective nutrient interaction in the participant's health record. **High Risk:** Use of drug or medication shown to interfere with nutrient intake or utilization, to extent that nutritional status is compromised.	**VI**
358	EATING DISORDERS Eating disorders (anorexia nervosa and bulimia), are characterized by a disturbed sense of body image and morbid fear of becoming fat. Symptoms are manifested by abnormal eating patterns including, but not limited to: • Self-induced vomiting • Purgative abuse • Alternating periods of starvation • Use of drugs such as appetite suppressants, thyroid preparations or diuretics • Self-induced marked weight loss Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Symptoms or diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed eating disorder	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
359	RECENT MAJOR SURGERY, TRAUMA OR BURNS Major surgery (including C-sections), trauma or burns severe enough to compromise nutritional status. Any occurrence within the past 2 months may be self reported. Any occurrence more than 2 months previous **MUST** have the continued need for nutritional support diagnosed by a physician or health care provider working under the standing orders of a physician. **Document:** If occurred within the past 2 months, document surgery, trauma and/or burns in the participant's health record. If occurred more than 2 months ago, document description of how the surgery, trauma and/or burns currently affects nutritional status and include date. **High Risk:** Major surgery, trauma or burns that has a continued need for nutritional support.	**VI**
360	OTHER MEDICAL CONDITIONS Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, **MUST** be severe enough to affect nutritional status. Including, but not limited to: juvenile rheumatoid arthritis (JRA), lupus erythematosus, cardiorespiratory diseases, heart disease, cystic fibrosis, moderate, Persistent Asthma (moderate or severe) requiring daily medication. Presence of medical condition(s) diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Specific medical condition; a description of how the disease, condition or treatment affects nutritional status and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed medical condition severe enough to compromise nutritional status	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
361	DEPRESSION Presence of depression diagnosed by a physician or psychologist as self reported by applicant/participant/caregiver; or as reported or documented by a physician, psychologist or health care provider working under the orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in participant's health record.	**VI**
362	DEVELOPMENTAL, SENSORY OR MOTOR DELAYS INTERFERING WITH THE ABILITY TO EAT Developmental, sensory or motor delays include but are not limited to: minimal brain function, feeding problems due to developmental delays, birth injury, head trauma, brain damage, other disabilities. **Document:** Specific condition/ description of delays and how these interfere with the ability to eat and the name of the physician that is treating this condition. **High Risk:** Developmental, sensory or motor delay interfering with ability to eat.	**VI**
363	PRE-DIABETES Presence of pre-diabetes diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or a health professional acting under standing orders of a physician **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed pre-diabetes	**VI**
371	MATERNAL SMOKING Any smoking of cigarettes, pipes or cigars. **Document:** Number of cigarettes or cigars smoked, or number of times pipe smoked, on WIC Assessment/Certification Form.	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
372	ALCOHOL AND ILLEGAL DRUG USE **Alcohol use:** • Routine current use of ≥ 2 drinks per day **OR** • Binge drinking is defined as ≥5 drinks on the same occasion on at least one day in the past 30 days, **OR** • Heavy drinking is defined as ≥5 drinks on the same occasion on five or more days in the past 30 days A serving of standard sized drink (1 ½ ounce of alcohol) is: - 1 can of beer (12 fluid oz) - 5 oz wine - 1 ½ fluid oz liquor **Document:** Alcohol Use; identify type (Routine - Enter oz./wk: ___, Binge drinker, Heavy drinker) on WIC Assessment/Certification Form. See Appendix E-1 for documentation codes. **Any Illegal drug use:** **Document:** Type of drug(s) being used. See Appendix E-2 for commonly used illegal drug names.	**VI**
381	DENTAL PROBLEMS Diagnosis of dental problems by a physician or health care provider working under the orders of a physician or adequate documentation by the competent professional authority. Including but not limited to: tooth decay, periodontal disease, and tooth loss and/or ineffectively replaced teeth which impair the ability to ingest food in adequate quality or quantity. **Document:** In the participant's health record, a description of how the dental problem interferes with mastication and/or has other nutritionally related health problems.	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
400	INAPPROPRIATE NUTRITION PRACTICES Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. (Appendix G) **Document:** Inappropriate Nutrition Practice(s) in the participant's health record.	**VI**
401	FAILURE TO MEET DIETARY GUIDELINES A woman who meets eligibility requirements based on category, income, and residency but who does not have any other identified nutritional risk factor may be **presumed** to be at nutritional risk based on failure to meet the *Dietary Guidelines for Americans*. **(This risk factor may be assigned only when a woman does not qualify for risk 400 or for any other risk factor.)**	**VI**
502	TRANSFER OF CERTIFICATION Person with a current valid Verification of Certification (VOC) document from another state or local agency. The VOC is valid until the certification period expires, and shall be accepted as proof of eligibility for Program benefits. If the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all other waiting applicants. This criterion should be used primarily when the VOC card/document does not reflect another more specific nutrition risk condition at the time of transfer or if the participant was initially certified based on a nutrition risk condition not in use by the receiving agency.	**III, VI**
801	HOMELESSNESS Homelessness as defined in the Special Populations Section of the Georgia WIC Program Procedures Manual.	**VI**

POSTPARTUM NON-BREASTFEEDING WOMEN		
CODE		**PRIORITY**
802	MIGRANCY Migrancy as defined in the Special Populations Section of the Georgia WIC Program Procedures Manual.	**VI**
901	RECIPIENT OF ABUSE Battering within past 6 months as self-reported, or as documented by a social worker, health care provider or on other appropriate documents, or as reported through consultation with a social worker, health care provider or other appropriate personnel. Battering refers to violent assaults on women.	**VI**
902	POSTPARTUM, NON-BREASTFEEDING WOMAN WITH LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD Woman who is assessed to have limited ability to make appropriate feeding decisions and/or prepare food. Examples may include: • mental disability / delay and/or mental illness such as clinical depression (diagnosed by a physician or licensed psychologist) • physical disability which restricts or limits food preparation abilities • current use of or history of abusing alcohol or other drugs **Document:** The women's specific limited abilities in the participant's health record.	**IV**
903	Foster Care Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months.	**VI**
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside the home.	**VI**

DATA AND DOCUMENTATION REQUIRED FOR WIC ASSESSMENT/CERTIFICATION

INFANTS

Data	Documentation		
	Infant Certified in Hospital Prior to Initial Discharge	**Infant**	**Infant Mid-Certification**
Length	Birth Data or other measurement	Required	Required
Weight	Birth Data or other measurement	Required	Required
Hematocrit or Hemoglobin	N/A	Required (9-12 months)	Required (9-12 months)
Weight for Age Plotted	Optional	Required	Required
Length for Age Plotted	Optional	Required	Required
Weight for Length Plotted	Optional	Required	Required
Evaluation of Inappropriate Nutrition Practices	Optional	Required	Required
Risk Factor Assessment	Required	Required	Required

NUTRITION RISK CRITERIA
INFANTS

NOTE: High Risk Criteria, as defined below, are to be used for referral purposes, not certification (See Appendix A-2)

INFANTS		
CODE		**PRIORITY**
201	LOW HEMOGLOBIN/HEMATOCRIT Hemoglobin: 10.9 gm or lower (6-11 month old) Hematocrit: 32.8% or lower (6-11 month old) **High Risk:** Hemoglobin **OR** Hematocrit at treatment level (Appendix B-2)	I
103	UNDERWEIGHT or AT RISK OF UNDERWEIGHT Less than or equal to the 5th percentile weight-for-length as plotted on the CDC Birth to 24 months gender specific growth charts.* **High Risk:** Less than or equal to the 2nd percentile weight-for-length as plotted on the CDC Birth to 24 months gender specific growth charts.* **Based on 2006 World Health Organization international growth standards. For the Birth to < 24 months "underweight" definition, CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	I
115	High Weight-for Length Greater than or equal to the 98th percentile weight-for-length as plotted on the Centers for Disease Control and Prevention (CDC), Birth to 24 months gender specific growth charts. **Based on the 2006 World Health Organization (WHO) international growth standards. CDC labels the 97.7th percentile as the 98th percentile on the Birth to 24 months gender specific growth charts.*	I

INFANTS		
CODE		**PRIORITY**
121	SHORT STATURE OR AT RISK OF SHORT STATURE Less than or equal to the 5th percentile length-for-age as plotted on the CDC Birth to 24 months gender specific growth charts.* **(if < 38 weeks gestation use adjusted age)** **High Risk:** Less than or equal to the 2nd percentile length-for-age as plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts.* **Based on 2006 World Health Organization international growth standard. CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	**I**
134	FAILURE TO THRIVE Presence of failure to thrive diagnosed by a physician or health professional acting under standing orders of a physician. **Document:** Diagnosis in the participant's health record **High Risk:** Diagnosed failure to thrive	**I**

INFANTS		
CODE		**PRIORITY**
135	INADEQUATE GROWTH An inadequate rate of weight gain as defined below: **Infants being certified during period from birth to 1 month of age:** ▪ Not back to birth weight by 2 weeks of age ▪ A gain of less than 19 ounces by 1 month of age **Infants being certified during period from 1 to 5½ months of age:** ▪ This method (explained in Appendix C-3) is optional, if an infant 1 to 5½ months of age qualifies for WIC based on any other risk criterion. If there is no other reason to qualify the infant, use this method to determine eligibility. **Infants 6 months to 12 months of age:** **Age in Months at Certification** — **Weight Gain per 6-month interval*** ▪ 5 ½ mos - 6 mos — ▪ ≤ 7 lbs ▪ >6 mos - 9 mos — ▪ ≤ 5 lbs ▪ >9 mos - 12 mos — ▪ ≤ 3 lbs ***Note:** Use this chart **only** for infants who are ≥ 5 months 2 weeks of age. Use **only** for an interval of 6 months +/- 2 weeks. **High Risk:** Inadequate growth	**I**
141	LOW BIRTH WEIGHT Birth weight ≤ 5 lbs 8 oz (≤ 2500 g) **Document:** Birth weight in participant's health record **High Risk:** Birth weight ≤ 5 lbs 8 oz (≤ 2500 g)	**I**

INFANTS		
CODE		**PRIORITY**
142	PREMATURITY Infant born at ≤ 37 weeks gestation **Document:** Weeks gestation in participant's health record	**I**
151	Small for Gestational Age Infants diagnosed as small for gestational age. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver.	**I**
152	Low Head Circumference Less than 2nd percentile head circumference-for-age as plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts **(if < 38 weeks gestation use adjusted age)** ** Based on 2006 World Health Organization international growth standards. CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	**I**
153	LARGE FOR GESTATIONAL AGE Birth weight ≥ 9 lbs or presence of large for gestational age diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or health care professional working under standing orders of a physician. **Document:** Weight(s) of infant in participant's health record.	**I**

INFANTS		
CODE		**PRIORITY**
211	ELEVATED BLOOD LEAD LEVELS Blood lead level of ≥ 10 μg/deciliter within the past 12 months. **Document:** Date of blood test and blood lead level in participant's health record. Must be within the past 12 months **High Risk:** Blood lead level of ≥ 10 μg/deciliter within the past 12 months.	I
NUTRITION RELATED MEDICAL CONDITIONS		
341	NUTRIENT DEFICIENCY DISEASES Diagnosis of clinical signs of nutritional deficiencies or a disease caused by insufficient dietary intake of macro or micro nutrients. Diseases include, but not limited to: protein energy malnutrition, hypocalcemia, cheilosis, scurvy, osteomalacia, menkes disease, rickets, Vitamin K deficiency, xerothalmia, beriberi, and pellagra. (See Appendix D) Presence of nutrient deficiency diseases diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record **High Risk:** Diagnosed nutrient deficiency disease	I

INFANTS		
CODE		**PRIORITY**
342	GASTRO-INTESTINAL DISORDERS Diseases or conditions that interfere with the intake, digestion, and or absorption of nutrients. The diseases and/or conditions include, but are not limited to: • Gastroesophageal reflux disease (GERD) • Peptic ulcer • Post-bariatric surgery • Short bowel syndrome • Inflammatory bowel disease, including ulcerative colitis or Crohn's disease • Liver disease • Pancreatitis • Biliary tract disease The presence of gastro-intestinal disorders as diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed gastro-intestinal disorder	**I**
343	DIABETES MELLITUS Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both. Presence of diabetes mellitus diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed diabetes mellitus	**I**

INFANTS		
CODE		**PRIORITY**
344	THYROID DISORDERS Thyroid dysfunctions that occur in fetal development and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following: • Congenital Hyperthyroidism: Excessive thyroid hormone levels at birth, either transient (due to maternal Grave's disease) or persistent (due to genetic mutation). • Congenital Hypothyroidism: Infants born with an under active thyroid gland and presumed to have had hypothyroidism in-utero. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed thyroid disorder	**I**
345	HYPERTENSION Presence of hypertension or prehypertension diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed hypertension	**I**
346	RENAL DISEASE Any renal disease including pyelonephritis and persistent proteinuria, but **EXCLUDING** urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed renal disease	**I**

INFANTS		
CODE		**PRIORITY**
347	CANCER A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, **must** be severe enough to affect nutritional status. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Description of how the condition or treatment affects nutritional status and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed cancer	**I**
348	CENTRAL NERVOUS SYSTEM DISORDERS Conditions which affect energy requirements and may affect the individual's ability to feed self, that alter nutritional status metabolically, mechanically, or both. Includes, but is not limited to: epilepsy, cerebal palsy (CP), and neural tube defects (NTD) such as spina bifida and myelomeningocele. Presence of a central nervous system disorder(s) diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed central nervous system disorder	**I**

INFANTS		
CODE		**PRIORITY**
349	GENETIC AND CONGENITAL DISORDERS Hereditary or congenital condition at birth that causes physical or metabolic abnormality, or both. May include, but not limited to: cleft lip, cleft palate, thalassemia, sickle cell anemia, down's syndrome. Presence of genetic and congenital disorders diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed genetic and congenital disorder	**I**
351	INBORN ERRORS OF METABOLISM Gene mutations or gene deletions that alter metabolism in the body, including, but not limited to: phenylketonuria (PKU), maple syrup urine disease, galactosemia, hyperlipoproteinuria, homocystinuria, tyrosinemia, histidinemia, urea cycle disorder, glutaric aciduria, methylmalonic acidemia, glycogen storage disease, galactokinase deficiency, fructoaldase deficiency, propionic acidemia, hypermethioninemia. **Presence of inborn errors of metabolism diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or** health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed inborn error of metabolism	**I**

INFANTS		
CODE		**PRIORITY**
352	INFECTIOUS DISEASES A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but is not limited to: tuberculosis, pneumonia, meningitis, parasitic infection, hepatitis, bronchiolitis (3 episodes in last 6 months), HIV/AIDS. The infectious disease **MUST** be present within the past 6 months and diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Diagnosis, appropriate dates of each occurrence, and name of physician treating condition in the participant's health record. When using HIV/AIDS positive status as a Nutritionally Related Medical Condition, write "See Medical Record" for documentation purpose. **High Risk:** Diagnosed infectious disease, as described above.	**I**
353	FOOD ALLERGIES An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed food allergy	**I**

INFANTS		
CODE		**PRIORITY**
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed Celiac Disease	**I**
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record; **OR** list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	**I**

INFANTS		
CODE		**PRIORITY**
356	HYPOGLYCEMIA Presence of hypoglycemia diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed hypoglycemia	**I**
357	DRUG/NUTRIENT INTERACTIONS Use of prescription or over the counter drugs or medications that have been shown to interfere with nutrient intake or utilization, to an extent that nutritional status is compromised. **Document:** Drug/medication being used and respective nutrient interaction in the participant's health record. **High Risk:** Use of drug or medication shown to interfere with nutrient intake or utilization, to extent that nutritional status is compromised.	**I**
359	RECENT MAJOR SURGERY, TRAUMA, BURNS Major surgery, trauma or burns severe enough to compromise nutritional status. Any occurrence within the past 2 months may be self reported, by caregiver. Any occurrence more than 2 months previous **MUST** have the continued need for nutritional support diagnosed by a physician or health professional acting under standing orders of a physician. **Document:** If occurred within the past 2 months, document surgery, trauma and/or burns in the participant's health record. If occurred more than 2 months ago, document description of how the surgery, trauma and/or burns currently affect nutritional status and include date. **High Risk:** Major surgery, trauma or burns that has a continued need for nutritional support.	**I**

INFANTS		
CODE		**PRIORITY**
360	OTHER MEDICAL CONDITIONS Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, **MUST** be severe enough to affect nutritional status. Including, but not limited to: juvenile rheumatoid arthritis (JRA), lupus erythematosus, cardiorespiratory diseases, heart disease, cystic fibrosis, moderate, Persistent Asthma (moderate or severe) requiring daily medication. Presence of medical condition(s) diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Specific medical condition; a description of how the disease, condition or treatment affects nutritional status and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed medical condition severe enough to compromise nutritional status.	**I**
362	DEVELOPMENTAL, SENSORY OR MOTOR DELAYS INTERFERING WITH ABILITY TO EAT Developmental, sensory or motor delays include but are not limited to: minimal brain function, feeding problems due to developmental delays, birth injury, head trauma, brain damage, other disabilities. Presence of developmental, sensory or motor delay diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Specific condition/ description of delays and how these interfere with the ability to eat and the name of the physician that is treating this condition. **High Risk:** Developmental, sensory or motor delay interfering with ability to eat.	**I**

INFANTS		
CODE		**PRIORITY**
381	DENTAL PROBLEMS Diagnosis of dental problems by a physician or health care provider working under the orders of a physician or adequate documentation by the competent professional authority. Including but not limited to: • Presence of nursing bottle caries • Smooth surface decay of the maxillary anterior and the primary molars **Document:** Description of how the dental problem interferes with mastication and/or has other nutritionally related health problems in the participant's health record.	**I**
382	FETAL ALCOHOL SYNDROME Fetal Alcohol Syndrome (FAS) is based on the presence of retarded growth, a pattern of facial abnormalities and abnormalities of the central nervous system, including mental retardation. Presence of FAS diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Diagnosis and name of physician treating the condition in the participant's health record. **High Risk:** Diagnosed fetal alcohol syndrome	**I**
400	INAPPROPRIATE NUTRITION PRACTICES Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. (Appendix G) **Document:** Inappropriate Nutrition Practice(s) in the participant's health record.	**IV**

INFANTS		
CODE		**PRIORITY**
428	Dietary Risk Associated with Complementary Feeding Practices **(Infants 4 to 12 months)** An infant ≥ 4 months of age who has begun to or is expected to begin to do any of the following practices is considered to be **at risk** of inappropriate complementary feeding: 1) consume complementary foods and beverages, or 2) eat independently, or 3) be weaned from breast milk or infant formula, or 4) transition from a diet based on infant/toddler foods to one based on the *Dietary Guidelines for Americans.* **(This risk factor may be assigned only when an infant ≥ 4 months of age does not qualify for risk 400 or for any other risk factor.)**	**IV**
502	TRANSFER OF CERTIFICATION Person with a current valid Verification of Certification (VOC) card from another state or local agency. The VOC card is valid until the certification period expires, and shall be accepted as proof of eligibility for program benefits. If the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all other waiting applicants. This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition at the time of transfer or if the participant was initially certified based on a nutrition risk condition not in use by the receiving State agency.	**I, II, IV**

INFANTS		
CODE		**PRIORITY**
603	BREASTFEEDING COMPLICATIONS OR POTENTIAL COMPLICATIONS Any of the following are considered complications or potential complications of breastfeeding: • Breastfed infant with jaundice • Breastfed infant with weak or ineffective suck • Breastfed infant with difficulty latching onto mother's breast • Breastfed infant with inadequate stooling for age (as determined by a physician or other health care provider) • Breastfed infant who wets diaper less than 6 times per day **Document:** Complications or potential complications in the participant's health record. **High Risk:** Refer to or provide the infant's mother with appropriate breastfeeding counseling.	**I**
701	INFANT UP TO 6 MONTHS OLD OF WIC MOTHER, **OR** OF A WOMAN WHO WOULD HAVE BEEN ELIGIBLE DURING PREGNANCY • An infant under 6 months of age whose mother was a WIC Program participant during pregnancy, **OR** • An infant whose mother's medical records document that the woman was at nutritional risk during pregnancy because of detrimental or abnormal nutrition conditions detectable by biochemical or anthropometric measurements or other documented nutritionally related medical conditions.	**II**
702	BREASTFEEDING INFANT OF A WOMAN AT NUTRITIONAL RISK A breastfed infant whose breastfeeding mother has been determined to be at nutritional risk. **Document:** Mother's risks on infant's WIC Assessment/Certification Form	**I, II, IV**

INFANTS		
CODE		**PRIORITY**
703	INFANT BORN TO MOTHER WITH MENTAL RETARDATION, OR ALCOHOL OR DRUG ABUSE DURING MOST RECENT PREGNANCY • Infant born of a woman diagnosed with mental retardation by a physician or psychologist as self-reported by caregiver; or as reported by a physician, psychologist, or someone working under physician's orders; **OR** • Documentation or self-report of any use of alcohol or illegal drugs during most recent pregnancy.	**I**
801	HOMELESSNESS Homelessness as defined in the Special Population Section of the Georgia WIC Procedures Manual.	**IV**
802	MIGRANCY Migrancy as defined in the Special Population Section of the Georgia WIC Procedures Manual.	**IV**
901	RECIPIENT OF ABUSE Child abuse/neglect within past 6 months as self-reported by the caregiver, or as documented by a social worker, health care provider or on other appropriate documents, or as reported through consultation with a social worker, health care provider or other appropriate personnel. Child abuse/neglect refers to any recent act, or failure to act, resulting in: • Imminent risk or serious harm • Serious physical or emotional harm • Sexual abuse or exploitation of an infant or child by a parent or caretaker. Georgia State law requires that medical and child service organization personnel, having reasonable cause to suspect child abuse, report these suspicions to the authority designated by the health district/organization.	**IV**

INFANTS		
CODE		**PRIORITY**
902	PRIMARY CAREGIVER WITH LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD Infant whose primary caregiver is assessed to have limited ability to make appropriate feeding decisions and/or prepare food. Examples may include: • mental disability / delay and/or mental illness such as clinical depression (diagnosed by a physician or licensed psychologist) • physical disability which restricts or limits food preparation abilities • current use of or history of abusing alcohol or other drugs **Document:** The caregivers limited abilities in the participant's health record.	**IV**
903	Foster Care Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months.	**IV**
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside the home.	**I**

DATA AND DOCUMENTATION REQUIRED FOR WIC ASSESSMENT/CERTIFICATION

CHILDREN

Data	Certification	Half-Certification
Length or Height	Required	Required
Weight	Required	Required
Hemoglobin or Hematocrit	Required	***
Weight/Age Plotted	Required	Required
Length or Height/Age Plotted	Required	Required
Weight/Length or BMI for Age Plotted	Required	Required
Evaluation of Inappropriate Nutrition Practices	Required	Required
Risk Factor Assessment	Required	Required

***Required when hemoglobin was low at most recent certification and for children less than 2 years old

NUTRITION RISK CRITERIA
CHILDREN

NOTE: High Risk Criteria, as defined below, are to be used for referral purposes, not certification (See Appendix A-2)

CHILDREN		
CODE		**PRIORITY**
201	LOW HEMOGLOBIN/HEMATOCRIT 12-23 months of age: Hemoglobin: 10.9 gm or lower Hematocrit: 32.8% or lower 24 months-5 years of age: Hemoglobin: 11.0 gm or lower Hematocrit: 32.9% or lower **High Risk:** Hemoglobin **OR** Hematocrit at treatment level (Appendix B-2)	**III**
103	**UNDERWEIGHT or AT RISK OF UNDERWEIGHT** **(Children 12-24 Months of Age)** Less than or equal to the 5th percentile weight-for-length as plotted on the CDC 12 to 24 months gender specific growth charts.* **High Risk:** Less than or equal to the 2nd percentile-weight-for-length as plotted on the CDC Birth to 24 months gender specific growth charts.* **Based on 2006 World Health Organization international growth standards. For the Birth to < 24 months "underweight" definition, CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	**III**
	UNDERWEIGHT or AT RISK OF UNDERWEIGHT **(Children 2-5 Years of Age)** Less than or equal to the 10th percentile Body Mass Index (BMI) for age based on Centers for Disease Control and Prevention (CDC) age/sex specific growth charts. **High Risk:** Less than or equal to the 5th percentile Body Mass Index (BMI)-for-age as plotted on the 2000 CDC age/gender specific growth charts.	

CHILDREN		
CODE		**PRIORITY**
113	OBESE (Children 2-5 Years of Age) Greater than or equal to 95th percentile Body Mass Index (BMI) or weight-for-stature as plotted on the 2000 Centers for Disease Control and Prevention (CDC) 2-20 years gender specific growth charts **High Risk:** Greater than or equal to 95th percentile BMI or weight-for-stature as plotted on the 2000 Centers for Disease Control and Prevention (CDC) 2-20 years gender specific growth charts	**III**
114	OVERWEIGHT **(Children 2-5 Years of Age)** Greater than or equal to 85th and less than 95th percentile Body Mass Index (BMI)-for-age or weight-for-stature as plotted on the 2000 Centers for Disease Control and Prevention (CDC) 2-20 years gender specific growth charts.* * The cut off is based on standing height measurements. Therefore, recumbent length measurements may not be used to determine this risk.	**III**
115	High Weight-for-Length (Children 12-24 Months of Age) Greater than or equal to the 98th percentile weight-for-length as plotted on the Centers for Disease Control and Prevention (CDC), Birth to 24 months gender specific growth charts.* **Based on the 2006 World Health Organization (WHO) international growth standards. CDC labels the 97.7th percentile as the 98th percentile on the Birth to 24 months gender specific growth charts.*	**III**

CHILDREN		
CODE		**PRIORITY**
121	SHORT STATURE OR AT RISK OF SHORT STATURE **(Children 12-24 Months of Age)** Less than or equal to the 5th percentile length-for-age as plotted on the CDC Birth to 24 months gender specific growth charts(1).* **(if < 38 weeks gestation use adjusted age)** **High Risk:** Less than or equal to the 2nd percentile length-for-age as plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts.* **Based on 2006 World Health Organization international growth standards. CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	**III**
	SHORT STATURE OR AT RISK OF SHORT STATURE **(Children 2-5 Years of Age)** Less than or equal to the 10th percentile length or height for age based on CDC age/sex specific growth charts. **High Risk:** Less than or equal to the 5th percentile stature-for-age as plotted on the 2000 CDC age/gender specific growth charts	
134	FAILURE TO THRIVE **Presence of failure to thrive diagnosed by a physician or health professional acting under standing orders of a physician.** **Document:** Diagnosis in participant's health record. **High Risk:** Diagnosed failure to thrive	**III**

CHILDREN		
CODE		**PRIORITY**
135	INADEQUATE GROWTH A low rate of weight gain over a six-month period as defined by the following chart: **Age in Months at Certification** — **Weight Gain in previous 6-month interval*** ▪ 12 months — ▪ ≤ 3 pounds ▪ >12 - 60 months — ▪ ≤ 1 pound ***Note:** Use **only** for an interval of 6 months +/- 2 weeks. **High Risk:** Inadequate growth	**III**
141	LOW BIRTH WEIGHT (**children < 24 months of age**) Birth weight ≤ 5 lbs 8 oz (≤ 2500 g) **Document:** Birth weight of participant in health record.	**III**
142	PREMATURITY **(Children < 24 months of age)** Born at 37 weeks gestation or less **Document:** Weeks gestation in participant's health record.	**III**
151	Small for Gestational Age (Children 12-24 Months of Age) Children less than 24 months of age diagnosed as small for gestational age. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver.	**III**

CHILDREN		
CODE		**PRIORITY**
152	Low Head Circumference (Children 12-24 Months of Age) Less than 2nd percentile head circumference-for-age as plotted on the Centers for Disease Control and Prevention (CDC) Birth to 24 months gender specific growth charts **(if < 38 weeks gestation use adjusted age)** ** Based on 2006 World Health Organization international growth standards. CDC labels the 2.3rd percentile as the 2nd percentile on the Birth to 24 months gender specific growth charts.*	**III**
211	ELEVATED BLOOD LEAD LEVELS Blood lead level of ≥10 μg/deciliter within the past 12 months. **Document:** Date of blood test and blood lead level in participant's health record. Must be within the past 12 months. **High Risk:** Blood lead level of ≥10 μg/deciliter **within the past 12 months.**	**III**
NUTRITION RELATED MEDICAL CONDITIONS		**III**
341	NUTRIENT DEFICIENCY DISEASES Diagnosis of clinical signs of nutritional deficiencies or a disease caused by insufficient dietary intake of macro or micronutrients. Diseases include, but not limited to: protein energy malnutrition, hypocalcemia, cheilosis, scurvy, osteomalacia, menkes disease, rickets, Vitamin K deficiency, xerothalmia, beriberi, and pellagra. (See Appendix D) Presence of nutrient deficiency diseases diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition participant's health record. **High Risk:** Diagnosed nutrient deficiency disease	

CHILDREN		
CODE		**PRIORITY**
342	GASTRO-INTESTINAL DISORDERS Diseases or conditions that interfere with the intake, digestion, and or absorption of nutrients. The diseases and/or conditions include, but are not limited to: • Gastroesophageal reflux disease (GERD) • Peptic ulcer • Post-bariatric surgery • Short bowel syndrome • Inflammatory bowel disease, including ulcerative colitis or Crohn's disease • Liver disease • Pancreatitis • Biliary tract disease The presence of gastro-intestinal disorders as diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed gastro-intestinal disorder	**III**
343	DIABETES MELLITUS Diabetes mellitus consists of a group of metabolic diseases characterized by inappropriate hyperglycemia resulting from defects in insulin secretion, insulin action or both. Presence of diabetes mellitus diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed diabetes mellitus	**III**

CHILDREN		
CODE		PRIORITY
344	THYROID DISORDERS Thyroid dysfunctions that occur in fetal development and in childhood are caused by the abnormal secretion of thyroid hormones. The medical conditions include, but are not limited to, the following: • Hyperthyroidism: Excessive thyroid hormone production (most commonly known as Graves' disease and toxic multinodular goiter). • Hyporthyroidism: Low secretion levels of thyroid hormone (can be overt or mild/subclinical). Most commonly seen as chronic autoimmune thyroiditis (Hashimoto's thyroiditis or autoimmune thyroid disease). It can also be caused by severe iodine deficiency. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed thyroid disorder	**III**
345	HYPERTENSION Presence of hypertension or prehypertension diagnosed by a physician as self reported by applicant/participant/caregiver; or as reported or documented by a physician, or someone working under physician's orders. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed hypertension	**III**
346	RENAL DISEASE Any renal disease including pyelonephritis and persistent proteinuria, but **EXCLUDING** urinary tract infections (UTI) involving the bladder. Presence of renal disease diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition participant's health record. **High Risk:** Diagnosed renal disease	**III**

CHILDREN		
CODE		**PRIORITY**
347	CANCER A chronic disease whereby populations of cells have acquired the ability to multiply and spread without the usual biologic restraints. The current condition, or the treatment for the condition, **must** be severe enough to affect nutritional status. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Description of how the condition or treatment affects nutritional status and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed cancer	**III**
348	CENTRAL NERVOUS SYSTEM DISORDERS Conditions which affect energy requirements and may affect the individual's ability to feed self, that alter nutritional status metabolically, mechanically, or both. Includes, but is not limited to: epilepsy, cerebal palsy (CP), and neural tube defects (NTD) such as spina bifida and myelomeningocele. Presence of a central nervous system disorder(s) diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed central nervous system disorder	**III**

CHILDREN		
CODE		**PRIORITY**
349	GENETIC AND CONGENITAL DISORDERS Hereditary or congenital condition at birth that causes physical or metabolic abnormality, or both. May include, but not limited to: cleft lip, cleft palate, thalassemia, sickle cell anemia, down's syndrome. Presence of genetic and congenital disorders diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document**: Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed genetic and congenital disorder	**III**
351	INBORN ERRORS OF METABOLISM Gene mutations or gene deletions that alter metabolism in the body, including, but not limited to: phenylketonuria (PKU), maple syrup urine disease, galactosemia, hyperlipoproteinuria, homocystinuria, tyrosinemia, histidinemia, urea cycle disorder, glutaric aciduria, methylmalonic acidemia, glycogen storage disease, galactokinase deficiency, fructoaldase deficiency, propionic acidemia, hypermethioninemia. **Presence of inborn errors of metabolism diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician.** **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed inborn error of metabolism	**III**

CHILDREN		
CODE		**PRIORITY**
352	INFECTIOUS DISEASES A disease caused by growth of pathogenic microorganisms in the body severe enough to affect nutritional status. Includes, but is not limited to: tuberculosis, pneumonia, meningitis, parasitic infection, hepatitis, bronchiolitis (3 episodes in last 6 months), HIV/AIDS. The infectious disease **MUST** be present within the past 6 months and diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Diagnosis, and approximate dates of each occurrence, and name of the physician that is treating this condition in the participant's health record. When using HIV/AIDS positive status as a Nutritionally Related Medical Condition, write "See Medical Record" for documentation purpose. **High Risk:** Diagnosed infectious disease, as described above.	**III**
353	FOOD ALLERGIES An adverse immune response to a food or a hypersensitivity that causes adverse immunologic reaction. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed food allergy	**III**

CHILDREN		
CODE		**PRIORITY**
354	CELIAC DISEASE Also known as Celiac Sprue, Gluten Enteropathy, or Non-tropical Sprue. Inflammatory condition of the small intestine precipitated by the ingestion of wheat in individuals with certain genetic make-up. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed Celiac Disease	**III**
355	LACTOSE INTOLERANCE Lactose intolerance occurs when there is an insufficient production of the enzyme lactase. Lactase is needed to digest lactose. Lactose in dairy products that is not digested or absorbed is fermented in the small intestine producing any or all of the following GI disturbances: nausea, diarrhea, abdominal bloating, cramps. Lactose intolerance varies among and within individuals and ranges from mild to severe. Presence of condition diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Diagnosis and the name of the physician that is treating this condition in the participant's health record; **OR** list of symptoms described by the applicant/participant/caregiver (i.e., nausea, cramps, abdominal bloating, and/or diarrhea).	**III**

CHILDREN		
CODE		PRIORITY
356	HYPOGLYCEMIA Presence of hypoglycemia diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed hypoglycemia	**III**
357	DRUG/NUTRIENT INTERACTIONS Use of prescription or over the counter drugs or medications that have been shown to interfere with nutrient intake or utilization, to an extent that nutritional status is compromised. **Document:** Drug/medication being used and respective nutrient interaction in the participant's health record. **High Risk:** Use of drug and medication shown to interfere with nutrient intake or utilization, to extent that nutritional status is compromised.	**III**
359	RECENT MAJOR SURGERY, TRAUMA, BURNS Major surgery, trauma or burns severe enough to compromise nutritional status. Any occurrence within the past 2 months may be self reported by caregiver. Any occurrence more than 2 months previous **MUST** have the continued need for nutritional support diagnosed by a physician or health professional acting under standing orders of a physician. **Document:** If occurred within the past 2 months, document surgery, trauma and/or burns in the participant's health record. If occurred more than 2 months ago, document description of how the surgery, trauma and/or burns currently affects nutritional status and include date. **High Risk:** Major surgery, trauma or burns that has a continued need for nutritional support.	**III**

CHILDREN		
CODE		**PRIORITY**
360	OTHER MEDICAL CONDITIONS Diseases or conditions with nutritional implications that are not included in any of the other medical conditions. The current condition, or treatment for the condition, **MUST** be severe enough to affect nutritional status. Including, but not limited to: juvenile rheumatoid arthritis (JRA), lupus erythematosus, cardiorespiratory diseases, heart disease, cystic fibrosis, moderate, Persistent Asthma (moderate or severe) requiring daily medication. Presence of medical condition(s) diagnosed, documented, or reported by a physician or someone working under a physician's orders, or as self reported by applicant/participant/caregiver. **Document:** Specific medical condition; a description of how the disease, condition or treatment affects nutritional status and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed medical condition severe enough to compromise nutritional status.	**III**
361	DEPRESSION Presence of depression diagnosed by a physician or psychologist as self reported by applicant/participant/caregiver; or as reported or documented by a physician, psychologist or health care provider working under the orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in participant's health record.	**III**

CHILDREN		
CODE		**PRIORITY**
362	DEVELOPMENTAL, SENSORY OR MOTOR DELAYS INTERFERING WITH ABILITY TO EAT Developmental, sensory or motor delays include but are not limited to: minimal brain function, feeding problems due to developmental delays, birth injury, head trauma, brain damage, other disabilities. Presence of developmental, sensory or motor delay diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Specific condition/description of the delay and how it interferes with the ability to eat, and the name of the physician that is treating this condition in the participant's health record. **High Risk:** Developmental, sensory or motor delay interfering with ability to eat.	**III**
381	DENTAL PROBLEMS Diagnosis of dental problems by a physician or health professional working under standing orders of a physician or adequate documentation by the competent professional authority. Including but not limited to: • Presence of nursing bottle caries • Smooth surface decay of the maxillary anterior and the primary molars **Document:** In the participant's health record, a description of how the dental problem interferes with mastication and/or has other nutritionally related health problems.	**III**

CHILDREN		
CODE		PRIORITY
382	FETAL ALCOHOL SYNDROME Fetal Alcohol Syndrome (FAS) is based on the presence of retarded growth, a pattern of facial abnormalities and abnormalities of the central nervous system, including mental retardation. Presence of FAS diagnosed by a physician as self reported by caregiver; or as reported or documented by a physician, or health professional acting under standing orders of a physician. **Document:** Diagnosis and name of the physician that is treating this condition in the participant's health record. **High Risk:** Diagnosed fetal alcohol syndrome	**III**
400	INAPPROPRIATE NUTRITION PRACTICES Routine nutrition practices that may result in impaired nutrient status, disease, or health problems. (Appendix G) **Document:** Inappropriate Nutrition Practice(s) in the participant's health record.	**V**
401	**FAILURE TO MEET DIETARY GUIDELINES FOR AMERICANS** **(Children 2-5 Years of Age)** A child who meets eligibility requirements based on category, income, and residency but who does not have any other identified nutritional risk factor may be **presumed** to be at nutritional risk based on failure to meet the *Dietary Guidelines for Americans*. **(This risk factor may be assigned only when a child does not qualify for risk 400 or for any other risk factor.)**	**V**

CHILDREN		
CODE		PRIORITY
428	**DIETARY RISK ASSOCIATED WITH COMPLEMENTARY FEEDING PRACTICES** **(Children 12-24 Months of Age)** A child who has begun to or is expected to begin to do any of the following practices is considered to be **at risk** of inappropriate complementary feeding: 1) consume complementary foods and beverages, or 2) eat independently, or 3) be weaned from breast milk or infant formula, or 4) transition from a diet based on infant/toddler foods to one based on the *Dietary Guidelines for Americans.* **(This risk factor may be assigned only when a child does not qualify for risk 400 or for any other risk factor.)**	**V**
502	TRANSFER OF CERTIFICATION Person with a current valid Verification of Certification (VOC) card from another state or local agency. The VOC card is valid until the certification period expires, and shall be accepted as proof of eligibility for program benefits. If the receiving local agency has waiting lists for participation, the transferring participant shall be placed on the list ahead of all other waiting applicants This criterion would be used primarily when the VOC card/document does not reflect another (more specific) nutrition risk condition at the time of transfer or if the participant was initially certified based on a nutrition risk condition not in use by the receiving State agency.	**III, V**
801	HOMELESSNESS Homelessness as defined in the Special Population Section of the Georgia WIC Procedures Manual.	**V**
802	MIGRANCY Migrancy as defined in the Special Population Section of the Georgia WIC Procedures Manual.	**V**

CHILDREN		
CODE		**PRIORITY**
901	RECIPIENT OF ABUSE Child abuse/neglect within past 6 months as self-reported by the caregiver, or as documented by a social worker, health care provider or on other appropriate documents, or as reported through consultation with a social worker, health care provider or other appropriate personnel. Child abuse/neglect refers to any recent act, or failure to act, resulting in: • Imminent risk or serious harm • Serious physical or emotional harm • Sexual abuse or exploitation of an infant or child by a parent or caretaker. Georgia State law requires that medical and child service organization personnel, having reasonable cause to suspect child abuse, report these suspicions to the authority designated by the health district/organization.	**V**
902	PRIMARY CAREGIVER WITH LIMITED ABILITY TO MAKE FEEDING DECISIONS AND/OR PREPARE FOOD Child whose primary caregiver is assessed to have limited ability to make appropriate feeding decisions and/or prepare food. Examples may include: • mental disability / delay and/or mental illness such as clinical depression (diagnosed by a physician or licensed psychologist) • physical disability which restricts or limits food preparation abilities • current use of or history of abusing alcohol or other drugs **Document:** The caregiver's limited abilities in the participant's health record.	**V**

CHILDREN		
CODE		**PRIORITY**
903	Foster Care Entering the foster care system during the previous six months or moving from one foster care home to another foster care home during the previous six months.	**V**
904	ENVIRONMENTAL TOBACCO SMOKE EXPOSURE Environmental tobacco smoke (ETS) exposure is defined as exposure to smoke from tobacco products inside the home.	**III**

TABLE OF APPENDICES

APPENDICES REFERENCED IN RISK CRITERIA SECTION

APPENDICES PROVIDED FOR SUPPLEMENTAL INFORMATION

Appendix A-1

WIC MATERNAL HIGH RISK CRITERIA

Any WIC prenatal, breastfeeding, or non-breastfeeding woman who has the following high risk factors must receive nutrition counseling specific to their nutritional condition and to the nutritional problems identified in their diet, as reflected in an individual care plan. In most instances, this counseling should be provided by a nutritionist. However, if the CPA determines that some other intervention or referral would be more appropriate, adequate documentation must be provided.

High Risk Criteria	Risk Code	Appendix
Hemoglobin or hematocrit at treatment level	201	B-1
Underweight ▪ Prenatal Women: Body Mass Index <18.5 ▪ Postpartum Women: Body Mass Index <18.5	101	C-1 Body Mass Index Tables
Overweight ▪ Prenatal Women: Body Mass Index >29.9 ▪ Postpartum Women: Current Body Mass Index >29.9	111	C-1 Body Mass Index Tables
Low maternal weight gain	131	C-2
Gestational weight loss during pregnancy greater than or equal to 2 pounds in the second and third trimester.	132	
Blood lead level > 10 μg/dl within the past 12 months.	211	
Hyperemesis Gravidarum	301	
Gestational diabetes	302	
EDC or delivery prior to 17th birthday	331	
Multi-fetal gestation	335	
Fetal Growth Restriction	336	
Nutrition-related medical conditions; presence of any disease or condition affecting nutritional status that requires a therapeutic diet as ordered by a physician or health professional acting under standing orders of a physician	341-349; 351-358, 360; 362	
Diagnosed pre-diabetes	363	
Breastfeeding complications; referral to appropriate BF counselor must be made	602	
Any condition deemed by the competent professional authority to place the woman at high risk for compromised nutritional status; adequate documentation required		

Appendix A-2

WIC HIGH RISK CRITERIA FOR INFANTS AND CHILDREN

WIC infants and children who have the following high risk factors must receive nutrition counseling specific to their nutritional condition and to the nutritional problems identified in their diet, as reflected in an individual care plan. In most instances, this counseling should be provided by a nutritionist. However, if the CPA determines that some other intervention or referral would be more appropriate, adequate documentation must be provided.

High Risk Criteria	Risk Code	Appendix
Hemoglobin or hematocrit at treatment level	201	B-2
Underweight or At Risk of Underweight (Infants and Children) Infants <12 Months of Age: Weight for length < 2nd percentile Children <24 Months of Age: Weight for length < 2nd percentile Children 2-5 Years of Age: BMI for age <5th percentile	103	
OBESE (Children 2-5 Years of Age) Body Mass Index for age >95th %	113	
Short stature Infants <12 Months of Age: Length-for-age < 2nd percentile Children <24 Months of Age: Weight for length < 2nd percentile Children 2-5 Years of Age: BMI for age <5th percentile	121	
Failure to thrive	134	
Inadequate growth	135	
Low birthweight infant (infant weighing 2500 grams [5 ½ pounds] or less at birth). May only be used for infants as high risk criteria.	141	
Blood lead level > 10μg/dl within the past 12 months.	211	
Nutrition-related medical conditions; presence of any disease or condition affecting nutritional status that requires a therapeutic diet or special prescribed formula as ordered by a physician or health professional acting under standing orders of a physician	341-357; 360; 362; 382	
Breastfeeding complications; infants only; referral to appropriate BF counselor must be made	603	
Any condition deemed by the competent professional authority to place the infant/child at high risk for compromised nutritional status; adequate documentation required		

Appendix B-1

WOMEN'S HEALTH
RECOMMENDED GUIDELINES FOR IRON SUPPLEMENTATION
BASED ON TREATMENT VALUES

	Hemoglobin Treatment Value		Hematocrit Treatment Value	
	Non-Smokers	**Smokers**	**Non-Smokers**	**Smokers**
Prenatal Woman 1st Trimester 3rd Trimester	10.9 gm or lower	11.2 gm or lower	32.9% or lower	33.9% or lower
Prenatal Woman 2nd Trimester	10.4 gm or lower	10.7 gm or lower	31.9% or lower	32.9% or lower
Non-Pregnant and/or Lactating Woman (<15 years of age)	11.7 gm or lower	12.0 gm or lower	35.8% or lower	36.8% or lower
Non-Pregnant and/or Lactating Woman (≥15 years of age)	11.9 gm or lower	12.2 gm or lower	35.8% or lower	36.8% or lower

For Prenatal Women:

Begin routine supplementation of a prenatal vitamin and mineral supplement to include 27-30 mg/day of elemental iron for all pregnant women at the 1st prenatal visit. For women with hemoglobin/hematocrit levels within the treatment value, treat anemia with a therapeutic dose of 60-120 mg of elemental iron/day.

NOTE: If a woman is taking a prenatal or other multi-vitamin and mineral supplement with iron, the prenatal or multi-vitamin and mineral supplement + iron supplement should equal a total of 60-120 mg elemental iron/day. When the hemoglobin/hematocrit reaches the acceptable value for the specific stage pregnancy, decrease iron dosage to 30 mg/day

PHYSICIAN REFERRAL:

- Hemoglobin less than 9.0 g/dL or hematocrit less than 27.0%
- Hemoglobin more than 15.0 g/dL or hematocrit more than 45.0% (2nd and 3rd trimester)
- If after 4 weeks the hemoglobin does not increase by 1 g/dL or hematocrit by 3%, despite compliance with iron supplementation regimen and the absence of acute illness

For Non-Pregnant/Lactating Women:

For women with hemoglobin/hematocrit levels within the treatment value, treat anemia with a therapeutic dose of 60-120 mg of elemental iron/day.

NOTE: If a woman is taking a prenatal or other multi-vitamin and mineral supplement with iron, the prenatal or multi-vitamin and mineral supplement + iron supplement should equal a total of 60-120 mg elemental iron/day.

PHYSICIAN REFERRAL:

- Hemoglobin less than 9.0 g/dL or hematocrit less than 27.0%
- If after 4 weeks the hemoglobin does not increase by 1 g/dL or hematocrit by 3%, despite compliance with iron supplementation regimen and the absence of acute illness

After 4 weeks, if the hemoglobin increases ≥ 1g/dl or if the hematocrit increases ≥ 3 %, continue treatment for 2-3 more months.

Reference: CDC/MMWR: April 3, 1998. Recommendations to Prevent and Control Iron Deficiency in the United States

Appendix B-2

CHILD HEALTH RECOMMENDED GUIDELINES FOR IRON SUPPLEMENTATION BASED ON TREATMENT VALUES

	Hemoglobin Treatment Value	Hematocrit Treatment Value	Treatment Regimen
Infant 6 through 11 months	10.9 gm or lower	32.8% or lower	Dosage: 0.6 cc Ferrous Sulfate Drops BID Mg Elemental Iron: 15 mg BID
Child 12 through 23 months	10.9 gm or lower	32.8% or lower	Dosage: 0.6 cc Ferrous Sulfate Drops BID Mg Elemental Iron: 15 mg BID
Child 2 through 5 years	11.0 gm or lower	32.9% or lower	Dosage: 1.2 cc Ferrous Sulfate Drops BID Mg Elemental Iron: 30mg BID

- Premature and low birth weight infants, infants of multiple births, and infants with suspected blood losses should be screened before 6 months of age, preferably at 6-8 weeks postnatal.
- Routine screening for iron deficiency anemia is not recommended in the first 6 months of life.
- Treatment of iron deficiency anemia is 3 mg per kilogram per day.
- Refer to the package insert of iron preparation to correctly calculate the appropriate dosage of elemental iron. Most pediatric chewable preparations (i.e., Feostat, 100 mg) contain 33 mg elemental iron per tablet as ferrous fumarate. Non-chewable preparations for older patients (i.e., Feosol, 300 mg) contain 60-65 mg per tablet or capsule elemental iron as ferrous sulfate.

Sources: Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, April 3, 1998/Vol.47/No. RR-3.

Nutrition Guidelines for Practice: A Manual for Providing Quality Nutrition Services. Nutrition Section, 1997.

Appendix C-1

Body Mass Index (BMI) Table for Determining Weight Classification for (Women) [1]

Height (Inches)	Underweight BMI <18.5	Normal Weight BMI 18.5-24.9	Overweight BMI 25.0-29.9	Obese BMI >29.9
58”	<89	89-118	119-142	>142
59”	<92	92-123	124-147	>147
60”	<95	95-127	128-152	>152
61”	<98	98-131	132-157	>157
62”	<101	101-135	136-163	>163
63”	<105	105-140	141-168	>168
64”	<108	108-144	145-173	>173
65”	<111	111-149	150-179	>179
66”	<115	115-154	155-185	>185
67”	<118	118-158	159-190	>190
68”	<122	122-163	164-196	>196
69”	<125	125-168	169-202	>202
70”	<129	129-173	174-208	>208
71”	<133	133-178	179-214	>214
72”	<137	137-183	184-220	>220

[1]Adapted from Institute *Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults*. National Heart, Lung and Blood Institute (NHLBI), National Institutes of Health (NIH). NIH Publication No. 98-4083.

*These calculations are based on estimated height and weights; your system will calculate a more exact BMI based on actual height and weights including fractional ounces and inches.

Definition of Weight Gain (Women)

Total Weight Gain Range (lbs)

Singleton Pregnancy

Prepregnancy Weight Groups	Definition (BMI)	Low Maternal Weight Gain	Recommended Weight Gain	High Maternal Weight Gain
Underweight	< 18.5	<28	28-40	> 40
Normal Weight	18.5 to 24.9	<25	25-35	> 35
Overweight	25.0 to 29.9	<15	15-25	> 25
Obese	≥ 30.0	<11	11-20	> 20

Multi-Fetal Weight Gain

Prepregnancy Weight Groups	Definition (BMI)	Low Maternal Weight Gain	Recommended Weight Gain	High Maternal Weight Gain
Underweight	< 18.5	There was insufficient information for the IOM committee to develop provisional guidelines for underweight woman with multiple fetuses.	1.5lbs/week during 2nd and 3rd trimesters	There was insufficient information for the IOM committee to develop provisional guidelines for underweight woman with multiple fetuses.
Normal Weight	18.5 to 24.9	<37	37-54	> 54
Overweight	25.0 to 29.9	<31	31-50	> 50
Obese	≥ 30.0	<25	25-42	> 42

Appendix C-3

Definition of Inadequate Growth for Infants 1-6 Months of Age

Inadequate growth for infants between 1 and 6 months of age is based on two weight measurements taken at least 1 month (4.3 weeks) apart, using the following guidelines:

Age	Minimum Acceptable Weight Gain
1 month	19 oz
1-2 months	27 oz/month (6 ¼ oz/wk)
2-3 months	19 oz/month (4 ½ oz/wk)
3-4 months	17 oz/month (4 oz/wk)
4-5 months	15 oz/month (3 ½ oz/wk)
5-6 months	13 oz/month (3 oz/wk)

Example:

Date of Measurement	Weight
09/13/98 (birth)	7 lbs 6 oz
10/26/98 (6 weeks, 1 day old)	9 lbs 3 oz

1. Calculate infant's age:

```
   98      10      26
 - 98      09      13
   ---------------------
           01 mo   13 days  = 1 month + 1 week + 6 days = about 1 mo + 2 wks
```

2. Calculate minimum acceptable weight gain:

   1st month minimum acceptable weight = 19 oz
   1-2 months minimum acceptable weight/wk = 6 ¼ oz (2x 6 ¼ = 12 ½ oz)
   Total acceptable weight = 19 oz + 12 ½ oz = 31½ oz = 1 lb 15 ½ oz

3. Compare actual weight gain (1 lb 13 oz) to acceptable minimum (1 lb 15 ½ oz). This infant's weight gain is below acceptable minimum, so you can apply the criterion for inadequate growth.

Appendix D

PHYSICAL SIGNS SUGGESTIVE OF NUTRIENT DEFICIENCIES

Body Area	Normal Appearance	Signs Suggestive of Nutrient Deficiency(ies)	Nutrient Consideration(s)
Hair	shiny; firm; not easily plucked	lack of natural shine; dull; thin; loss of curl; color changes (flag sign); easily plucked	inadequate protein and calories
Eyes	bright; clear; shiny; no sores at corners of eyelids;	eye membranes pale;	anemia (inadequate iron, folacin, or vitamin B-12)
	membranes healthy pink and moist; no prominent blood vessels	Bitot's spots; red membranes; dryness of membranes; dull appearance of cornea (cornea xerosis); softening of cornea (keratomalacia);	inadequate Vitamin A
		redness and fissuring of eyelid corners	inadequate riboflavin, Vitamin B-6, and niacin
Lips	smooth; not chapped or swollen	redness or swelling of mouth or lips (cheilosis);	inadequate niacin and riboflavin
		bilateral cracks, white or pink lesions at corners of mouth (angular stomatitis) and/or scars	inadequate riboflavin, niacin, iron and Vitamin B-6
Gums	healthy, red; do not bleed; not swollen	spongy; bleeding; receding	inadequate ascorbic acid
Tongue	deep red; not swollen or smooth	scarlet; raw; edematous (glossitis)	inadequate niacin, riboflavin, folacin, iron, Vitamins B-6 and B-12
		purplish color (magenta);	inadequate riboflavin
		smooth; pale; slick; atrophied taste buds (papillae)	inadequate folacin, Vitamin B-12, iron and niacin
Face and Neck	skin color uniform, smooth, pink; healthy appearing; not swollen	diffuse depigmentation;	inadequate protein
		darkening of skin over cheeks and under eyes;	inadequate calories and niacin
		scaling of skin around nostrils (nasolabial seborrhea)	inadequate riboflavin, niacin, and Vitamin B-6
		swollen (moon) face;	inadequate protein
		front of neck swollen (thyroid enlargement);	inadequate protein; inadequate iodine
		swollen cheeks (bilateral parotid enlargement)	inadequate protein

PHYSICAL SIGNS SUGGESTIVE OF NUTRIENT DEFICIENCIES

Body Area	Normal Appearance	Signs Suggestive of Nutrient Deficiency(ies)	Nutrient Consideration(s)
Skin	no signs of swelling rashes, dark or light spots	dry and scaly (xerosis); sandpaper-like feel (follicular hyperkeratosis);	Inadequate Vitamin A or Essential fatty acids
		pinhead-size purplish skin hemorrhages (petechiae);	Inadequate Vitamin C
		excessive bruising;	Inadequate Vitamin K
		red, swollen pigmentation of areas exposed to sunlight (pellagrous dermatitis);	Inadequate niacin and Tryptophan
		extensive lightness and darkness of skin (flaky, pressure sores(decubiti)	Inadequate protein, Vitamin C, and zinc
Teeth	no cavities, no pain, bright	may be some missing or erupting abnormally; gray or black spots (fluorosis); cavities (caries) [signs are to be severe enough to interfere with mastication and/or other health implications]*	Inadequate Vitamin D and Vitamin A
Head / Neck	face not swollen	thyroid enlargement (front of neck); parotid enlargement (cheeks become swollen)	Inadequate iodine; inadequate protein
Nails	firm, pink	nails are spoon-shaped (koilonychia); brittle ridged nails, pale nail beds	Inadequate iron; Vitamin A toxicity
Muscular and Skeletal Systems	good muscle tone; some fat under skin; can walk or run without pain	muscles have “wasted” appearance; baby’s skull bones are thin and soft (craniotabes); round swelling of front and side of head (frontal and parietal bossing); swelling of ends of bones (epiphyseal enlargement); small bumps on both sides of chest wall (on ribs); beading of ribs; baby’s soft spot on head does not harden at proper time (persistently open anterior fontanelle); knock-knees or bow-legs; bleeding into muscle (musculoskeletal hemorrhages); person cannot get up or walk properly	Inadequate protein Inadequate thiamin Inadequate Vitamin D

Sources: 1. American Journal of Public Health, Supplement, November 1973, p. 19.

2. Georgia Dietetic Association Diet Manual, 1992.

Appendix E-1

ALCOHOL AND CIGARETTES

Alcohol Equivalents:

One serving of alcohol = 12 ounces of beer (light or regular);

12 ounces of wine cooler;

5 ounces of wine (light or regular);

1 1/2 ounces of liquor.

Key for Entering Ounces of Alcohol/Week:
On the WIC Assessment/Certification Form enter the amount of alcohol in ounces per week using the above equivalent chart.

Key: 00 ounces/week = no alcohol intake

01 ounces/week = greater than 0 and up to 1 1/2 ounce/week

02-98 ounces week = amount of intake

99 ounces/week = greater than 98 ounces/week

Binge drinking: drinks 5 or more (≥5) drinks on the same occasion on at least one day in the past 30 days.

Heavy drinking: drinks 5 or more (≥5) drinks on the same occasion on five or more days in the previous 30 days.

Key for Entering Number of Cigarettes/Cigars/Pipes Smoked:
On the WIC Assessment/Certification Form record the average number of cigarettes/cigars/pipes smoked per day. If the client reports smoking on average less than once per day, record the average number of cigarettes/cigars/pipes smoked *per week*. If the client reports smoking on average less than once per week, record the average number of cigarettes/cigars/pipes smoked *per month*.

Key: 01-98/day = average number of cigarettes/cigars/pipes smoked per day

99/day = greater than 98 cigarettes/cigars/pipes smoked per day

01-06/week = average number of cigarettes/cigars/pipes smoked per week

01-03/month = average number of cigarettes/cigars/pipes smoked per month

Note: The usual number of cigarettes in a pack is equal to 20. This number may vary.

Appendix E-2

COMMON NAMES FOR ILLEGAL (STREET) DRUGS/DRUGS OF ABUSE

Controlled Substances	Common Names
Cannabis:	
▪ Marijuana	▪ Acapulco Gold, Grass, Pot, Reefer, Sinsemilla, Thai Sticks
▪ Tetrahydrocannabinol	▪ Marinol, THC
▪ Hashish, Hashish Oil	▪ Hash, Hash Oil
Hallucinogens:	
▪ LSD (lysergic acid diethylamide)	▪ Acid, Microdot
▪ Mescaline, Peyote	▪ Buttons, Cactus, Mescal
▪ Amphetamine Variants	▪ 2,5-DMA, DOB, DOM, Ecstasy, MDA, MDMA, STP
▪ Phencyclidine and Analogs	▪ Angel Dust, Hog, Loveboat, PCE, PCP, PCPy, TCP
Narcotics:	
▪ Heroin	▪ Diacetylmorphine, Horse, Smack
Stimulants:	
▪ Cocaine	▪ Coke, Crack, Flake, Snow, Rock

Source: Drugs of Abuse. Drug Enforcement Administration and The National Guard. Arlington, VA, 1997.

Appendix F

RECOMMENDED FOOD INTAKE PATTERNS

Food Group	Birth to 5/6 Months	5/6 Months to 12 months	1 Year	2-3 Years	4-6 Years	Pregnant Teen/ Pregnant Adult	Breastfeeding Teen/ Breastfeeding Adult	Teen Postpartum/ Adult Postpartum
Milk, Yogurt & Cheese	Breast milk, every 2-3 hrs or Iron fortified formula, 2.5 oz/lb (18-35 ozs)	Breast milk, every 2-4 hrs or Iron fortified formula, 2.5 oz/lb (24-35 ozs)	2 cups[1]	2 cups	2.5 cups	3 cups	3 cups	3 cups
Meat, Poultry, Dry Beans, Eggs, Nuts Group	None	Add after 6 months and before 9 months	2 ounces	2 ounces	3-4 ounces	6- 6 ½ ounces	6 ½ ounces	5- 5 ½ ounces
Fruit Group	None	Add after 6 months and before 9 months	1 cup[2]	1 cup[2]	1- 1 ½ cups	2 cups	2-2 ½ cups	1 ½ -2 cups
Vegetable Group	None	Add after 6 months and before 9 months	1 cup	1 cup	1 ½ cups	3 cups	3-3 ½ cups	2 ½ cups
Grain Group	None	Add iron Fortified cereal at 6 months	3 oz equivalents	3 oz equivalents	4- 5 oz equivalents	7- 8 oz equivalents	7- 8 ½ oz equivalents	6 oz equivalents
Discretionary Calorie Allowance[3]	None	None	165	165	171	290- 362	362- 410	195-267

[1] If there is obesity, high cholesterol or heart disease in their family history, the AAP recommends reduced fat 2 percent milk between 12 months and 2 years in place of whole. WIC regulations at this time does not allow for the issuance of low fat milk below the age of 2.

[2] AAP recommends no more than 6 ounces of juice per day for children

[3] Discretionary Calorie Allowance is the remaining amount of calories in a food intake pattern after accounting for the calories needed for all food groups- preferably using forms of foods that are fat-free or low-fat and with no added sugars.

Milk, Yogurt & Cheese Group:
Most milk group choices should be fat-free or low-fat for those over the age of 2 years.
1 cup equivalent from this group =
1 cup milk/yogurt

1½ ounces natural cheese (i.e. cheddar, Colby, longhorn)
2 ounces processed cheese (i.e. American, Swiss)
2 cups cottage cheese

Meat, Poultry, Dry Beans, Eggs, Nuts Group:
1 ounce equivalent from this group=
1 ounce lean meat, poultry or fish

1 egg
½ ounce nuts or seeds
¼ cup cooked dry beans or tofu
1 tablespoon peanut butter

Fruit Group:
1 cup equivalent from this group=
1 medium fruit

1 cup freshly cut canned or frozen fruit
½ cup dried fruit
1 cup 100% fruit juice

Vegetable Group:

1 serving =

1 cup cooked or chopped
2 cups raw leafy salad greens
1 cup 100% vegetable juice

Grain Group:
At least half of all grains consumed should be whole grains
1ounce equivalent from this group =

1 slice of Bread ,½ Hamburger Bun,
1 small muffin
½ cup cooked cereal, rice or pasta
1 cup ready to eat cereal flakes

All information provided courtesy of MyPyramid.gov
For more information http://download.journals.elsevierhealth.com/pdfs/journals/1499-4046/PIIS1499404606005628.pdf

Appendix G

Inappropriate Nutrition Practices for Women

Inappropriate Nutrition Practices for Women	Examples of Inappropriate Nutrition Practices (Including but not limited to)
Potentially Harmful Dietary Supplements Consuming Dietary Supplements with potentially harmful consequences.	Examples of Dietary supplements which when ingested in excess of recommended dosages, may be toxic or have harmful consequences: • Single or multiple vitamins • Mineral supplements; and • Herbal or botanical supplements/remedies/teas.
Restrictive Diet Consuming a diet very low in calories and/or essential nutrients; or impaired caloric intake or absorption of essential nutrients following bariatric surgery.	• Strict vegan diet; • Low-carbohydrate, high-protein diet; • Macrobiotic diet; and • Any other diet restricting calories and/or essential nutrients.
Routine ingestion of non-food items (pica) Compulsively ingesting non-food items (pica).	Non-food items: • Ashes; • Baking soda; • Burnt matches; • Carpet fibers; • Chalk; • Cigarettes; • Clay; • Dust; • Large quantities of ice • Paint chips; • Soil; and • Starch (laundry and cornstarch)
Inadequate vitamin/mineral supplementation recognized as essential by national public health policy.	• Consumption of less than 27 mg of supplemental iron per day by pregnant woman. • Consumption of less than 150 µg of supplemental iodine per day by pregnant and breastfeeding woman. • Consumption of less than 400 mcg of folic acid from fortified foods and/or supplements daily by non-pregnant women
Pregnant Women	
Potentially unsafe food consumption Pregnant woman ingesting foods that could be contaminated with pathogenic microorganisms.	Potentially harmful foods: • Raw fish or shellfish, including oysters, clams, mussels, and scallops; • Refrigerated smoked seafood, unless it is an ingredient in a cooked dish, such as a casserole; • Raw or undercooked meat or poultry; • Hot dogs, luncheon meat (cold cuts), fermented and fry sausage and other deli-style meat or poultry unless reheated until steaming hot; • Refrigerated pâté or meat spreads; • Unpasteurized milk or foods containing unpasteurized milk; • Soft cheese such as feta, Brie, Camembert, blue-veined cheeses and Mexican style cheese such as queso blanco, queso fresco, or Panela unless labeled as “made with pasteurized milk”; • Raw or undercooked eggs or foods containing raw or lightly cooked eggs including certain salad dressings, cookie and cake batters, sauces, and beverages such as unpasteurized eggnog; • Raw sprouts (alfalfa, clover, and radish); or • Unpasteurized fruit or vegetable juices.

Inappropriate Nutrition Practices for Children

Inappropriate Nutrition Practices for Children	Examples of Inappropriate Nutrition Practices (Including but not limited to)
Routinely feeding inappropriate beverages as the primary milk source.	Examples of inappropriate beverages as primary milk source: • Non-fat or reduced-fat milks (between 12 and 24 months of age only) or sweetened condensed milk; and • Imitation or substitutes milks (such as inadequately or unfortified rice- or soy-based beverages, non-dairy creamer), or other "homemade concoctions."
Routinely feeding a child any sugar-containing fluids.	Examples of sugar-containing fluids: • Soda/soft drinks; • Gelatin water; • Corn syrup solutions; and • Sweetened tea.
Routinely using nursing bottle, cups, or pacifiers improperly.	• Using a bottle to feed: ➢ Fruit juice, or ➢ Diluted cereal or other solid foods. • Allowing the child to fall asleep or be put to bed with a bottle at naps or bedtime. • Allowing the child to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier. • Using a bottle for feeding or drinking beyond 14 months of age. • Using a pacifier dipped in sweet agents such as sugar, honey, or syrups. • Allowing a child to carry around and drink, throughout the day, from covered or training cups.
Routinely using feeding practices that disregard the developmental needs or stages of the child.	• Inability to recognize, insensitivity to, or disregarding the child's cues for hunger and satiety (e.g., forcing a child to eat a certain type and/or amount of food or beverage or ignoring a hungry child's request for appropriate foods). • Feeding foods of inappropriate consistency, size, or shape that put children at risk of choking. • Not supporting a child's need for growing independence with self-feeding (e.g.; solely spoon-feeding a child who is able and ready to finger-feed and/or try self-feeding with appropriate utensils). • Feeding a child with an inappropriate texture based on his/her developmental stage (e.g., feeding primarily purees or liquid food when the child is read and capable of eating mashed, chopped, or appropriate finger food).

Inappropriate Nutrition Practices for Children	Examples of Inappropriate Nutrition Practices (Including but not limited to)
Potentially unsafe food consumption. **Feeding foods to a child that could be contaminated with harmful microorganisms.**	Examples of potentially harmful foods for a child: • Unpasteurized fruit or vegetable juices. • Unpasteurized dairy products or soft cheese such as feta, Brie, Camembert, blue-veined cheeses and Mexican style cheese such as queso blanco, queso fresco, or Panela unless labeled as "made with pasteurized milk • Raw or undercooked meat, fish, poultry, or eggs • Raw sprouts (alfalfa, clover, and radish) • Hot dogs, luncheon meat (cold cuts), fermented and fry sausage and other deli-style meat or poultry unless reheated until steaming hot;
Routinely feeding a diet very low in calories and/or essential nutrients.	Examples: • Vegan Diet; • Macrobiotic diet; and • Other diets very low in calories and/or essential nutrients.
Feeding dietary supplements with potentially harmful consequences	Examples of dietary supplements which when feed in excess of recommended dosages, may be toxic or have harmful consequences: • Single or multiple vitamins • Mineral supplements; and • Herbal or botanical supplements/remedies/teas
Routinely not providing dietary supplements as recognized as essential by national public health policy when a child's diet alone cannot meet nutrient requirements.	• Providing children under 36 months of age less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride. • Providing children 36-60 months of age less than 0.50 mg of fluoride daily when the water contains less than 0.3 ppm fluoride. • Not providing 400 IU of vitamin D if a child consumes less than 1 liter (or 1 quart) of vitamin D fortified milk or formula.
Routine ingestion of non-food items (pica)	• Ashes; • Carpet fibers; • Cigarettes or cigarette butts; • Clay; • Dust; • Foam Rubber • Paint chips; • Soil; and • Starch (laundry and cornstarch)

Inappropriate Nutrition Practices for Infants

Inappropriate Nutrition Practices for Infants	Examples of Inappropriate Nutrition Practices (Including but not limited to)
Breast-milk or Formula Substitute Routinely using a substitute(s) for breast milk or FDA approved iron-fortified formula as the primary source during the first year of life.	Examples of substitutes: • Low iron formula without iron supplementation; • Cow's milk, goat milk, or sheep milk (whole, reduced-fat low-fat, skim) canned evaporated sweetened condensed milk; and • Imitation or substitutes milks (such as inadequately or unfortified rice- or soy-based beverages, non-dairy creamer), or other "homemade concoctions."
Inappropriate use of bottles or Sugar-Containing Fluids. Routinely using nursing bottles or cups improperly	• Using a bottle to feed fruit juice • Adding any food (cereal or other solid foods) to the infant's bottle. • Feeding any sugar-containing fluids such as, soda/soft drinks; gelatin water; corn syrup solutions; and sweetened tea. • Allowing the child to fall asleep or be put to bed with a bottle at naps or bedtime. • Allowing the child to use the bottle without restriction (e.g., walking around with a bottle) or as a pacifier. • Propping the bottle when feeding. • Allowing a child to carry around and drink, throughout the day, from covered or training cups.
Inappropriate Introduction of Solid Foods Routinely offering complementary foods* or other substances that are inappropriate in type or timing.	• Adding sweet agents such as sugar, honey, or syrups to any beverage (including water) or prepared food, or used on a pacifier; or • Introduction of any food other than breast milk or iron-fortified infant formula before 4 months of age. **Complementary foods are any foods or beverages other than breast milk or infant formula.*
Feeding Practices not Developmentally Appropriate Routinely using feeding practices that disregard the developmental needs or stages of the child.	• Inability to recognize, insensitivity to, or disregarding the child's cues for hunger and satiety (e.g., forcing an infant to eat a certain type and/or amount of food or beverage or ignoring a hungry infant's hunger cues). • Feeding foods of inappropriate consistency, size, or shape that put infants at risk of choking. • Not supporting an infant's need for growing independence with self-feeding (e.g.; solely spoon-feeding an infant who is able and ready to finger-feed and/or try self-feeding with appropriate utensils). • Feeding an infant with an inappropriate texture based on his/her developmental stage (e.g., feeding primarily purees or liquid food when the child is read and capable of eating mashed, chopped, or appropriate finger food).

Inappropriate Nutrition Practices for Infants	Examples of Inappropriate Nutrition Practices (Including but not limited to)
Potentially unsafe food consumption Feeding foods to a child that could be contaminated with harmful microorganisms or toxins.	Examples of potentially harmful foods for a child: • Unpasteurized fruit or vegetable juices. • Unpasteurized dairy products or soft cheese such as feta, Brie, Camembert, blue-veined cheeses and Mexican style cheese such as queso blanco, queso fresco, or Panela unless labeled as "made with pasteurized milk • Honey (added to liquids or solid food, used in cooking, as part of processed foods, on pacifier, etc.); • Raw or undercooked meat, fish, poultry, or eggs • Raw vegetable sprouts (alfalfa, clover, bean and radish) • Hot dogs, luncheon meat (cold cuts), fermented and fry sausage and other deli-style meat or poultry unless reheated until steaming hot;
Inappropriate Formula Preparation. Routinely feeding inappropriately diluted formula	• Failure to follow manufacturer's dilution instructions (to include stretching formula for household economic reasons). • Failure to follow specific instructions accompanying a prescription.
Restrictive Nursing. Routinely limiting the frequency of nursing of the exclusively breastfeed infant when breast milk is the sole source of nutrients.	Examples of inappropriate frequency of nursing: • Scheduled feedings instead of demand feedings; • Less than8 feedings in a 24 hours if less than 2 months of age; and • Less than 6 feedings in 24 hours if between 2 and 6 months of age.
Restrictive Diet Routinely feeding a diet very low in calories and/or essential nutrients	Examples: • Vegan Diet; • Macrobiotic diet; and • Other diets very low in calories and/or essential nutrients
Lack of proper Sanitation. Routinely using inappropriate sanitation in preparation, handling, and storage of expressed breast milk or formula.	Examples of inappropriate sanitation: • Limited or no access to a: Safe water supply (documented by appropriate officials) Heat source for sterilization, and/or; Refrigerator or freezer storage. • Failure to properly prepare, handle, and store bottles or storage containers of expressed breast milk or formula.
Potentially Harmful Dietary Supplements. Feeding dietary supplements with potentially harmful consequences	Examples of Dietary supplements which when feed in excess of recommended dosages, may be toxic or have harmful consequences: • Single or multiple vitamins • Mineral supplements; and • Herbal or botanical supplements/remedies/teas
Lack of Essential Dietary Supplements. Routinely not providing dietary supplements as recognized as essential by national public health policy when an Infant's diet alone cannot meet nutrient requirements.	• Infants who are 6 months of age or older who are ingesting less than 0.25 mg of fluoride daily when the water supply contains less than 0.3 ppm fluoride. • Infants who are exclusively breastfed, or are ingesting less than 1 liter (or 1 quart) per day of vitamin D-fortified formula, and are not taking a supplement of 400 IU of vitamin D. • Non-breastfed infants who are ingesting less than 1 liter (or 1 quart) per day of vitamin D-fortified formula, and are not taking a supplement of 400 IU of vitamin D.

Appendix H

PRODUCTS CONTAINING CAFFEINE

PRODUCT	AVERAGE CAFFEINE CONTENT (mg)	CAFFEINE RANGE (mg)
Coffee (5-oz cup)		
Brewed, drip	115	60-180
Brewed, percolator	80	40-170
Instant	65	30-120
Decaffeinated, brewed	3	2-5
Decaffeinated, instant	2	1-5
Tea		
Brewed, major US brands (5-oz)	40	20-90
Brewed, imported brand (5-oz)	60	25-110
Instant (5-oz)	30	25-50
Iced (12-oz)	70	67-76
Chocolate Beverages		
Cocoa beverage (5-oz)	4	2-20
Chocolate milk (8-oz)	5	2-7
Milk chocolate (1-oz)	6	1-15
Dark choc, semi-sweet (1 oz)	20	5-35
Baker's chocolate (1 oz)	26	26
Chocolate-flavored syrup (1 oz)	4	4

PRODUCT	CAFFEINE CONTENT (mg)
Energy Drinks (16-oz)	
Monster Energy	160.0
Rock Star Energy Drink	160.0
Red Bull	160.0
Full Throttle	144.0
5 Hour Energy (2-oz)	138.0
Soft Drinks (12-oz)	
Mountain Dew	54.0
Mello Yellow	52.8
TAB	46.8
Coca-Cola	45.6
Diet Coke	44.4
Mr. PIBB	39.6
Dr. Pepper	39.6
Pepsi Cola	38.0
Diet Pepsi	36.0

PRODUCTS CONTAINING CAFFEINE

PRODUCT	MILLIGRAMS CAFFEINE/DOSE
Diet Plan Non-Prescription Drugs	
Caltrim Tablets	100
Caffeine-Free Dexatrim w/ Vitamin C	0
Dexatrim	200
X-tra Strength Dexatrim	200
Gold Medal	100
Odrinex	
Pain Relievers	
Anacin and X-tra Strength	32
Capron Capsules	32.4
Tri Pain Caplets	16.2
BC Tablet	16
BC Powder	32
Arthritis Strength BC	36
Doan's Pills	32
Duradyne	15
Excedrin X-tra Strength	65
Goody's Powder	32.5
Goody's X-tra Strength	16.25
Meadache	32
Trigesic	30
Vanquish Caplet	33
Prolamine Capsules	140
Menstrual Relief	
Aqua Ban	100
Midol	32.4
Midol Max Strength, Multi-Symptom	60

Sources:

[1]American Pharmaceutical Association and The National Professional Society of Pharmacists. (8th Ed.). (1986). *Handbook of Nonprescription Drugs*.

[2]American Dietetic Association (ADA). (1992). *Manual of Clinical Dietetics* (4th ed.). Chicago, IL: Chicago Dietetic Association.

[3]Georgia Dietetic Association (GDA). (1992). *Georgia Dietetic Association Diet Manual* (4th ed.). Duluth, GA.

[4]Medical Economics Data Production Company. (15th Ed.). (1994). *Physician's Desk Reference for Nonprescription Drugs*, Montvale, N.J.

[5]U.S. Pharmacopeial Convention, Inc. (13th Ed.). (1993). *Drug Information for the Health Care Professional USP DI*.

Appendix I

INSTRUCTIONS FOR USE OF THE PRENATAL WEIGHT GAIN GRID

1. Record applicant/participant's name.

2. Use Body Mass Index table (Appendix C-1) to determine if the applicant is Normal Weight, Underweight , Overweight , or Obese using pregravid weight. Select for use the prenatal weight gain grid that corresponds to the prenatal woman's pregravid weight status. If she is pregnant with twins, use the "Twins" grid regardless of her weight status.

3. Enter height in inches without shoes.

4. Use Weight History chart.

5. Enter pregravid weight as indicated. Enter date and weight at each visit.

6. Plot today's weight using the following steps:

    a. Record the pregravid weight at the initial point of the selected weight curve, which is located on the left side of the grid at zero (0) point. From the chart or gestation calculator, determine the completed weeks of gestation.

    b. Using the gain (or loss) in weight from the pregravid weight baseline and the completed gestational weeks (this visit) place an **X** on the point at which these two (2) lines meet.

    c. If the patient does not know her pregravid weight, or if the weight she gives seems disproportionate to her current weight, place an **X** on the dotted line for the calculated completed gestational week. Let this be a beginning point to plot future weights. Indicate that this weight is an estimate by writing "estimate" vertically on the grid next to the **X**. Use the "Normal" weight curve unless it is very obvious that the prenatal woman was overweight or underweight prior to gestation. Document this observation in the health record.

    d. At the second and each subsequent visit, the weight gain for completed weeks of gestation should be plotted on the grid.

MEASURING LENGTH

Age:

Birth to 24 months

Material/Equipment:

An accurate lengthboard for measuring infants is dedicated to length measurement. It has a firm, flat horizontal surface with a measuring tape in 1 mm (0.1 cm) or 1/8 inch increments, an immovable headpiece at a right angle to the tape, and a smoothly moveable footpiece, perpendicular to the tape.

Two (2) people required

Procedure:

1. Check to be sure that moveable foot piece slides easily and the headboard is at the zero (0) mark.

2. Remove headwear, shoes and bulky clothing. Instruct caretaker to apply gentle traction to ensure that the child's head is firmly against the headboard so that the eyes are pointing directly upward.

3. With the child positioned so that the shoulders, back and buttocks are flat along the center of the board, the measurer should hold the child's knees together, gently pushing them down against the board with one (1) hand to fully extend the child. With the other hand the measurer should slide the footboard to the child's feet until both heels touch the foot piece. Toes should be pointing directly upward.

4. Recheck head placement. Immediately remove the child's feet from contact with the footboard with one (1) hand, while holding the footboard securely in place with the other hand.

5. Measure length in inches to the nearest 1/8-inch. Repeat the measurement by sliding footboard away and starting again until two (2) readings agree within 1/4 inch.

6. Record the second reading promptly.

MEASURING WEIGHT
("INFANT" SCALE)

Age:

Infants and very young children up to 35 pounds

Materials/Equipment:

Scales with beam balance and non-detachable weights or electronic, with a maximum weight of 40 lbs and weigh in ½ ounce increments.

Scales must be calibrated yearly.

Procedure:

1. Check scales at zero (0) position. With weights in zero (0) position, indicator should point at zero (0). If not, use the adjustment screws to move adjustable zeroing weight until the beam is in zero (0) balance.

2. Remove shoes and clothes. Remove diaper if wet.

3. Place infant/child in center of scale (may be done sitting or lying down).

4. Move the weight on the main beam away from the zero (0) position (left to right) until the indicator shows excess weight, then move the weight back (right to left) towards the zero (0) position until too little weight has been obtained.

5. Move the weight on the fractional beam away from the zero (0) position (left to right) until the indicator is centered and stationary. (Record weight)

6. Repeat the measurements by moving the fractional beam until two (2) readings agree within ½ -ounce.

7. Record the second reading promptly.

Appendix J-3

MEASURING HEIGHT

Age:

Children two (2) years of age and older

Adults

NOTE: Once measurements are started with child standing, all subsequent measurements must be done standing.

Material/Equipment:

An accurate stadiometer for stature measurements is designed for and dedicated to stature measurement. It can be wall mounted or portable. An appropriate stadiometer requires a vertical board with an attached metric rule and a horizontal headpiece (right angle headboard) that can be brought into contact with the most superior part of the head. The stadiometer should be able to read to 0.1 cm or 1/8 in.

Procedure:

1. Remove all bulky clothing, head and footwear.

2. Position the child/adult against the measuring device, instructing the child/adult to stand straight and tall.

3. Make sure the child/adult stands flat footed with feet slightly apart and knees extended; then check for three (3) contact points: (a) shoulders, (b) buttocks, and (c) the back of the heels.

4. Lower the moveable headboard until it firmly touches the crown of the head. The child/adult should be looking straight ahead, not upward or down at the floor.

5. Read the stature to the nearest 1/8-inch.

6. Repeat the adjustment of the headboard and re-measure until two (2) readings agree within 1/4 inch.

7. Record the second reading promptly.

MEASURING WEIGHT
(STANDING)

Age:

Adults, and children 2 years of age or older

Materials/Equipment:

Standard electronic scale or platform beam scale with non-detachable weights that weighs in at least 1/4 pound or 100 gram increments.

Scales must be calibrated yearly

Procedure:

1. Check scales at zero (0) position. With weights in zero (0) position indicator should point at zero (0). If not, use adjustment screws to move the adjustable zeroing weight until the beam is in zero (0) balance.

2. Should be wearing minimal indoor clothing. Remove shoes, heavy clothing, belts, and heavy jewelry. Be sure pockets are empty.

3. Have child/adult stand in the center of the platform, arms hanging naturally. The child/adult must be free standing.

4. Move the weight on the main beam away from zero (0) until the indicator shows that excess weight has been added, then move the weight back towards the zero (0) position (right to left) until just barely too much weight has been removed.

5. Move the weight on the fractional beam away from the zero (0) position (left to right) until the indicator is centered.

6. Make sure the child/adult is still not holding on, then record to the nearest 1/4 lb.

7. Have the child/adult step off scale and return weight to zero (0). Repeat until two (2) readings agree within 1/4 pound.

8. Record the second reading promptly.

Sources: Georgia Child and Adolescent Health Program Manual. DHR, Division of Public Health; 1987.
A Guide to Pediatric Weighing and Measuring, DHHS; 1981.

Appendix K

INSTRUCTIONS FOR USE OF THE GROWTH CHARTS

1. Select the appropriate chart for sex and age of the individual. When length measurements are taken with the individual lying down use the "Birth to 24 Months of Age" chart.

2. Record name and/or identifying number of the chart. Document birth date.

3. The child's age on the date on which measurements are taken must be determined before you start plotting the measurements. To figure out a child's age, follow this example:

	Year	Month	Day
Date of Measurement	2002	4	21
Date of Birth	-1997	-8	-10
Child's Age	4 y	8	11
	or 4 yrs 8 mos		

As this example shows, you may have to borrow thirty (30) days from the month column and/or 12 months from the year column when subtracting the child's birth date from the date on which the measurements are taken.

4. Plot growth measurements by using the Interpolation Method.

Plotting Interpolation Method:

a. **Birth - 24 Month Growth Chart** - Calculate exact age (to nearest week) and plot measurement into the space at the point nearest to the age.
b. **2 - 18 Years Growth Chart** - Calculate exact age (to nearest month) and plot measurement into space at the point nearest to the age.

5. To plot the length or height for age and weight for age charts:

a. Follow a vertical line at the appropriate age.

b. Using a straight-edge, line up as closely as possible to the measured length or height and weight and mark the point where the two (2) lines intersect.

c. Write the date above the point.

6. To plot the length or height/weight chart:

    a. Follow a vertical line at the point of the correct length or height.

    b. Using a straight-edge, line up as closely as possible to the weight and mark the point where the two (2) lines intersect.

    c. Write the date on the point.

7. To plot Body Mass Index (BMI) for age:

    a. Follow a vertical line as near as possible to the appropriate age.

    b. Using a straight-edge, line up as closely as possibly the measured BMI and mark the point where the two (2) lines intersect.

8. To plot an infant's head circumference:

    a. Follow a vertical line as near as possible to the appropriate age.

    b. Using a straight-edge, line up as closely as possible the measured head circumference and mark the point where the two (2) lines intersect.

9. Calculating Gestation-Adjusted Age:

    a. Document the infant’s gestational age in weeks. (Mother/caregiver can self report, or referral information from the medical provider may be used.)

    b. Subtract the child’s gestational age in weeks from 40 weeks (gestational age of term infant) to determine the adjustment for prematurity in weeks.

    c. Subtract the adjustment for prematurity in weeks from the child’s chronological postnatal age in weeks to determine the child’s gestation-adjusted age.

    d. For WIC nutrition risk determination, adjustment for gestational age should be calculated for all premature infants for the first 2 years of life.

Example:
Randy was born prematurely on March 19, 2001. His gestational age at birth was determined to be 30 weeks based on ultrasonographic examination. At the time of the June 11, 2001 clinic visit, his chronological postnatal age is 12 weeks. What is his gestation-adjusted age?

30 = gestational age in weeks
40 – 30 = 10 weeks adjustment for prematurity
12 – 10 = 2 weeks gestation-adjusted age

Measurements would be plotted on a growth chart as a 2-week-old infant.

10. Plotting for Prematurity:

For all premature infants and children <24 months plot adjusted and actual age.

a. Infant Plot- (weight/age, Length/age, length/weight)

b. Child Plot- (weight/age, height/age, BMI)

11. The formula for calculating BMI for age is:

[weight (lb.) ÷ height (in.) ÷ height (in.) x 703]

This can be calculated on a hand-held calculator or by computer systems in the district. Once calculated, BMI must be rounded to one decimal point. A reference for converting fractions to decimals and guidance for rounding to one decimal point follows.

Reference for Converting Fractions to Decimals:

1/8 = .125

2/8 or ¼ = .25

3/8 = .375

4/8 or ½ = .5

5/8 = .625

6/8 or ¾ = .75

7/8 = .875

Guidance for Rounding to One Decimal Point:

When calculating Body Mass Index (BMI) round the final answer to one decimal point. To do this you will round up to the next number if the second number past the decimal point is five or greater and you will round down if the second number past the decimal point is four or less.

Example:
If the final BMI calculation equals 17.158829, the BMI would be 17.2

If the final BMI calculation equals 17.14829, the BMI would be 17.1

Appendix L

USE AND INTERPRETATION OF THE GROWTH CHARTS

PLOTTING

1. Standing height and weight must be plotted on the **2-18 Years** growth charts.
2. Recumbent length and weight must be plotted on the **0-24 Months** growth charts.
3. When a measurement cannot be plotted, a notation to this effect must be noted in the health record or on the growth chart. This measurement may not be used as a risk criterion. See the following example:

   Standing height is measured on a 26-month old child. The child is 34 7/8 inches tall. Two options may be taken:

   a. Re-measure the child on the recumbent board, and plot length on the 0-36 months growth chart; OR

   b. Make a notation in the health record that the height of the child cannot be plotted on the 2-18 years growth chart.

INTERPRETATION

1. **Pattern of growth** can only be interpreted when two sets of measurements are plotted on the same growth grid. If one set of measurements are plotted on the 0-24 months growth charts and the next set of measurements on the 2-18 years growth charts, these measurements cannot be used to interpret the **pattern of growth** of the child.

Appendix M

FOOD SOURCES OF VITAMIN A

Food Source	Serving Size	Vitamin A (mcg Retinol)*
Apricots		
canned	3 halves	140
dried	10 halves	250
raw	3 medium	280
Bok Choy	1 cup	110
Broccoli		
cooked	1 cup	110
raw	1 cup	680
Carrots		
cooked	1cup	1920
raw	1 medium	2030
Cantaloupe, cubed	1 cup	520
Endive, raw	1cup	50
Greens, fresh, cooked		
beet	1cup	370
collards	1cup	350
kale	1cup	480
turnip	1cup	400
spinach	1cup	740
Liver, beef	3 ounces	10,600
Mango, raw	1 medium	810
Papaya, raw	1 medium	620
Parsley, chopped	1cup	160
Peaches		
canned, juice pack	1 cup	100
raw	1 medium	50
dried	10 halves	280
Persimmon, raw	1 medium	360
Pumpkin, canned	1cup	2690
Sweet Potato, baked	1 medium	2490
Watercress, raw	1cup	80
Winter Squash, baked	1cup	240

*Micrograms of retinol equivalent: rounded to the nearest 10

Appendix N

FOOD SOURCES OF VITAMIN C

Food Source	Serving Size	Vitamin C (mg)*
Broccoli, chopped		
cooked	1/2 cup	60
raw	1/2 cup	40
Cantaloupe, raw	1 cup, pieces	70
Green Pepper	1/2 medium	40
Grapefruit		
juice**, from concentrate	1/2 cup	40
raw	1/2 medium	50
Mango, raw	1 medium	60
Orange		
juice**, from concentrate	1/2 cup	50
raw (navel)	1 medium	80
Strawberries, raw	1 cup	90
Tomato, raw	1 medium	20

*Milligrams Vitamin C: rounded to nearest 10
**Items distributed through the Georgia WIC Program.

Appendix O

Selected Food Sources of Folate and Folic Acid

Food Source / Serving Size	Micrograms (µg)	% DV^
*Breakfast cereals fortified with 100% of the DV, ¾ cup	400	100
Beef liver, cooked, braised, 3 ounces	185	45
Cowpeas (blackeyes), immature, cooked, boiled, ½ cup	105	25
*Breakfast cereals, fortified with 25% of the DV, ¾ cup	100	25
Spinach, frozen, cooked, boiled, ½ cup	100	25
Great Northern beans, boiled, ½ cup	90	20
Asparagus, boiled, 4 spears	85	20
*Rice, white, long-grain, parboiled, enriched, cooked, ½ cup	65	15
Vegetarian baked beans, canned, 1 cup	60	15
Spinach, raw, 1 cup	60	15
Green peas, frozen, boiled, ½ cup	50	15
Broccoli, chopped, frozen, cooked, ½ cup	50	15
*Egg noodles, cooked, enriched, ½ cup	50	15
Broccoli, raw, 2 spears (each 5 inches long)	45	10
Avocado, raw, all varieties, sliced, ½ cup sliced	45	10
Peanuts, all types, dry roasted, 1 ounce	40	10
Lettuce, Romaine, shredded, ½ cup	40	10
Wheat germ, crude, 2 Tablespoons	40	10
Tomato Juice, canned, 6 ounces	35	10
Orange juice, chilled, includes concentrate, ¾ cup	35	10
Turnip greens, frozen, cooked, boiled, ½ cup	30	8
Orange, all commercial varieties, fresh, 1 small	30	8
*Bread, white, 1 slice	25	6
*Bread, whole wheat, 1 slice	25	6
Egg, whole, raw, fresh, 1 large	25	6
Cantaloupe, raw, ¼ medium	25	6
Papaya, raw, ½ cup cubes	25	6
Banana, raw, 1 medium	20	6

* Items marked with an asterisk (*) are fortified with folic acid as part of the Folate Fortification Program.

^ DV = Daily Value. DVs are reference numbers developed by the Food and Drug Administration (FDA) to help consumers determine if a food contains a lot or a little of a specific nutrient. The DV for folate is 400 micrograms (µg). Most food labels do not list a food's magnesium content. The percent DV (%DV) listed on the table indicates the percentage of the DV provided in one serving. A food providing 5% of the DV or less is a low source while a food that provides 10-19% of the DV is a good source. A food that provides 20% or more of the DV is high in that nutrient. It is important to remember that foods that provide lower percentages of the DV also contribute to a healthful diet. For foods not listed in this table, please refer to the U.S. Department of Agriculture's Nutrient Database Web site: http://www.nal.usda.gov/fnic/cgi-bin/nut_search.pl.

Sources: U.S. Department of Agriculture, Agricultural Research Service. 2003. USDA National Nutrient Database for Standard Reference, Release 16. Nutrient Data Laboratory Home Page, http://www.nal.usda.gov/fnic/cgi-bin/nut_search.pl

Appendix P

FOOD SOURCES OF IRON

Food Source	Serving Size	Iron (mg)
Iron Fortified Breakfast Cereal*	¾ cup	8-18
Canned Clams	1/3 cup	11
Cooked Oysters	3 oz	7
Blackstrap Molasses	1 Tbsp.	5
Liver	2 ounces	5
Baked Beans	1 cup	5
Spinach	1 cup	4
Red Meat	3 ounces	3
Prunes	10 large	3
Raisins	1/2 cup	3
Pork	3 ounces	3
Turkey	3 ounces	3
Baked Potato with skin	1	3
Ham	3 ounces	2
Legumes, cooked*	1/2 cup	2
Raw Shrimp	3 ounces	2
Baked Winter Squash	1 cup	2
Berries	1 cup	1.5 – 2
Turnip or Collard Greens	1 cup	1.5
Liverwurst	1 slice	1
Chicken	3 ounces	1
Fish	3 ounces	1
Prune Juice	1/3 cup	1

*Items distributed through the Georgia WIC Program.

Appendix Q

FOOD SOURCES OF CALCIUM

	250 mg	150-249 mg	75-149 mg
MILK GROUP	Milks - 1 cup Whole - 291 mg 1% lowfat - 300 mg 2% lowfat 297 mg Skim - 302 mg Buttermilk - 285 mg Chocolate 284 mg Malted - 348 mg Swiss Cheeses 272 mg Ricotta, part skim, ½ c - 337 mg Milkshakes - 1 cup Chocolate 397 mg Vanilla 457 mg Yogurt, lowfat - 1 cup Plain 415 mg Flavored 380 mg Fruit 345 mg	Cheeses - 1 oz. American, processed, 174 mg Blue 150 mg Brick 191 mg Caraway 204 mg Cheddar 204 mg Colby 194 mg Edam 207 mg Monterey 212 mg Mozzarella, part skim 183 mg Muenster 203 mg Cheese food American, processed, 163 mg Swiss, processed 205 mg	Cottage Cheese, 2% Lowfat, ½ c, 75 mg Frozen desserts – ½ c Ice cream 88 mg Ice milk, hardened, 88 mg Ice Milk, soft serve, 137 mg Pudding, 133 mg
MEAT/PROTEIN GROUP	Sardines, with bones, 3 oz, 372 mg Tofu, firm processed with calcium- sulfate, 4 oz, 250-765 mg	Salmon, with bones 167 mg. - 3 oz Sesame seeds 2 TB, 176 mg.	Beans, dried, cooked, 90 mg. - 1 c Oysters, 7-9, 113 mg Shrimp, canned, 3 oz, 100 mg Tofu, soft, ½ c, 145 mg Tahini (sesame butter) 2 TB, 128 mg. Soybeans, 8 oz, 64 mg Soy beverage, 8 oz, 64 mg Almonds, 1 oz, 75 mg
VEGETABLE GROUP	Cooked, 1 cup Collards, 357 mg Rhubarb, 348 mg Spinach, 278 mg Bok Choy, 252 mg	Cooked, 1 cup Kale, 200 mg Mustard greens, 200 mg Turnip greens, 249 mg	Cooked, 1 cup Okra, 176 mg Broccoli, 90 mg
FRUIT			Figs, dried or fresh 5 med, 135 mg. Papaya, raw – 1 med, 72 mg. Sapote, raw – 1 med, 88 mg. Tamarind, raw - 1 c, 89 mg.
GRAIN GROUP		Waffle, 7" diameter, 179 mg	Cornbread, 2" square , 94 mg Pancakes, 2-4" diameter, 116 mg
"OTHERS" Category fats, sweets, alcohol	Molasses, Blackstrap, 2 Tbsp., 274 mg		
COMBINATION FOODS: Foods made with ingredients from more than one food group	Cheese pizza, 3 of 14" pie, 332 mg	Macaroni and cheese, ½ c c, 181 mg Soups made with milk - 1 c Cream of mushroom , 191 mg Cream of tomato, 168 mg Taco, beef, 174 mg	Chili con carne with beans, 1 c, 82 mg Custard, baked, ½ c, 148 mg Spaghetti, meatballs, tomato sauce, and cheese, 1 c, 124 mg

Sources: (1) Pennington, JAT. *Bowes & Church's Food Values of Portions Commonly Used.* 16th edition. Philadelphia, PA: J.B. Lippincott Co.; 1994. (2) Georgia Dietetic Association Diet Manual. Georgia Dietetic Association, Inc. Fourth edition, 1992. (3) National Osteoporosis Foundation 1991.

HERBS: THEIR USE AND POTENTIAL RISKS

Herbs	Use	Risks
Chamomile	Relaxant	May cause allergic reaction (up to anaphylactic shock in allergic individuals).
Ginseng	Health food remedy	Painful, swollen breasts
Mandrake	Sold falsely as Ginseng	Contains scopolamine
Pennyroyal oil	Abortifacient	Toxicity, teratogenesis, increased risk of medical abortion, hepatotoxin, coma death
Sassafras	Tonic for a variety of unsubstantiated uses	Possible carcinogenesis
Tonka beans, melilot, sweet woodruff (tea)	Seasonal tonic	Hemorrhage
Devil's claw root	Abortifacient	Sodium and water retention, hypokalemia, hypertension, cardiac failure/arrest
Ginger root tea	Morning sickness remedy	Unknown - very large doses may cause depression of CNS, and cardiac arrhythmias.

There is insufficient information on many herbs that women may want to use during pregnancy and lactation. Herbs have been used as remedies for years and in many cases some may be beneficial. The problems that might arise may be dose related, which could affect the fetus and growing infant. A Asafe≅ level or Adangerous≅ level is generally not known for use in pregnancy and lactation; avoidance of most herbs is usually the best practice. In addition to the herbs listed above, the following herbs are recommended NOT to be used during pregnancy and lactation:

Angelica	Elecampane
Black Cohosh	Gotu kola
Blessed Thistle	Juniper Berries
Calendula	Motherwart
Dong Quai	Myrrh

Sources: Dimperio, Diane: Florida Department of Health and Rehabilitative Services, Florida's Guide to Maternal Nutrition, 1986.
Tenney, Louise: Today's Herbal Health, 3rd Edition, Woodland Books, Utah, 1992.
Tyler, Varro E.: The Honest Herbal, 3rd Edition, Pharmaceutical Products Press, New York, 1993.

Appendix S

KEY FOR ENTERING WEEKS BREASTFED

The number of weeks breastfed must be manually entered when completing paper WIC Assessment/Certification Forms and paper Turnaround Documents for:

- Breastfeeding women: initial and six month certification visits
- Postpartum, non-breastfeeding women: certification visit
- Infants: initial certification and mid-certification nutrition assessments
- Children: initial certification and subsequent certification, until the answer is "No"

Length of time breastfed **must be entered in weeks (two-digit).** When the answer to the question "How long have you breastfed this infant?" OR "How long has this infant breastfed?" is given in days or months, use the following key to determine appropriate codes.

I. Codes to Enter When Breastfeeding is Given in Days

Convert Days to Weeks		
Fewer than 7 days	=	00 weeks
7 - 13 days	=	01 week
14 – 20 days	=	02 weeks
21 – 27 days	=	03 weeks
28 – 34 days	=	04 weeks
35 – 41 days	=	05 weeks
42 – 48 days	=	06 weeks

Source: Georgia WIC Branch ETAD Change Number 08-12b, 2008.

II. Codes to Enter When Breastfeeding is Given in Months

1 month	=	04 weeks	12 Months	=	52 weeks
2 months	=	08 weeks	13 Months	=	56 weeks
3 months	=	13 weeks	14 Months	=	61 weeks
4 Months	=	17 weeks	15 Months	=	65 weeks
5 Months	=	22 weeks	16 Months	=	69 weeks
6 Months	=	26 weeks	17 Months	=	74 weeks
7 Months	=	30 weeks	18 Months	=	78 weeks
8 Months	=	35 weeks	19 Months	=	82 weeks
9 Months	=	39 weeks	20 Months	=	87 weeks
10 Months	=	43 weeks	21 Months	=	91 weeks
11 Months	=	48 weeks	22 Months	=	96 weeks
			22.5 Months +	=	98 weeks or more

Source: Enhanced Pregnancy Nutrition Surveillance System User's Manual. Division of Nutrition, Center for Chronic Disease Prevention & Health Promotion, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Public Health Service. February 2000.

Infant Formula Preparation

GENERAL INFORMATION

1. Before starting, wash hands with soap and water. Rinse well.

2. Wash bottles and nipples using brushes made for bottles and nipples. Wash caps, rings and preparation utensils such as spoons, pitchers, etc. Use hot soapy water. Rinse well.

3. Squeeze clean water through the nipple holes to be sure they are open.

4. Put the bottles, nipples, caps and rings and other utensils in a pot and cover with water. Heat on the stove, bring to a boil; boil for 5 minutes. Remove from heat and let cool.
   OR
   Put all items in a properly functioning dishwasher and run it at the normal temperature (not the low or economy temperature setting).

5. The most important time to boil bottles, nipples and formula preparation items for the infant is through 3 months of age. Also, the most important time to boil the water used in formula preparation is through 3 months of age. **If there is any doubt about the safety of the water supply or the cleanliness of the home, then continue to sterilize the equipment and to boil the water used in formula preparation.**

6. Boil water for 2 minutes before using to prepare formula. Prolonged boiling of water (greater than 5-6 minutes) is not recommended because some trace contaminates in the water such as lead, nitrates, or even trace minerals may concentrate in the boiled water as the liquid water is reduced.

7. Do not feed an infant a bottle left out of the refrigerator for more than 1 hour.

8. For infants who prefer a warmed bottle, hold the bottle under warm running tap water. Shake well and test the temperature before giving to the infant. **Do not use microwave oven to prepare or to warm formula. Formula heated in the microwave may result in serious burns to the infant.**

9. When using formula:

   - Check the formula's expiration date prior to use. Do not use if the date has passed.
   - Avoid using cans of infant formula that have dents, leaks, bulges or puffed ends or rust spots.

Infant Formula Preparation

9. (Cont'd)
   - Store cans of infant formula in a cool place, indoors. Do not store in vehicles, garages or outdoors.
   - For more information, see the following references:
     - Infant formula cans - commercial brands.
     - United States Department of Agriculture, Food and Nutrition Service. *Infant Nutrition and Feeding, a Reference Handbook for Nutritional Health Counselors in the WIC and CSF Programs*. FNS-288, September 1993. USDA, FNS, Alexandria, Virginia 22302-1594. (U.S. Gov. Printing Office: 1994-0-360-395 QL.3).

PREPARATION FROM CONCENTRATED LIQUID FORMULA

1. Boil for 5 minutes all bottles, nipples, rings and utensils to be used; let cool.
2. Heat water for formula on stove to a rolling boil for 2 minutes; let cool.
3. Wash top of the can with soap and water; rinse well. Wash the can opener.
4. Shake can well before opening.
5. Open can and pour formula into a clean bottle using ounce markings to measure amount of formula. **Add an equal amount of the cooled boiled water**. Example: For 4 ounces of concentrated formula poured into the bottle, add 4 ounces of water. Shake or stir again.
6. To store: cover container or bottles and refrigerate. ***Use within 48 hours***. If more than one bottle is prepared, put the nipples in upside down on each bottle. Cover the nipple with a cap and screw on the ring.
7. After feeding, throw away any formula left in bottle or cup, as this can contain germs.

Note: *Do not use microwave oven to prepare or to warm formula. Formula heated in the microwave may result in burns.*

PREPARATION OF READY-TO-FEED FORMULA

1. Boil for 5 minutes all bottles, nipples, rings and utensils to be used; let cool.
2. Wash top of the can with soap and water; rinse well. Wash the can opener.
3. Shake can **very** well. Open with a clean punch-type can opener.
4. Pour the amount of ready-to-feed formula for one feeding into a clean bottle.

Note: *Do not add water or any other liquid to this formula.*

5. Attach nipple and cap. Shake well again and feed infant.

Infant Formula Preparation

6. If more than one bottle is prepared, put the nipples in upside down on each bottle. Cover the nipple with a cap and screw on the ring. Refrigerate. If formula is left in opened can, cover and refrigerate. **Use within 48 hours**. Shake can again before pouring; or shake bottles before serving.

Note: *Do not use microwave oven to prepare or to warm formula. Formula heated in the microwave may result in burns.*

Preparation from Powdered Formula

1. Boil for 5 minutes all bottles, nipples, rings and utensils to be used; let cool.
2. Heat water for formula on stove to a rolling boil for 2 minutes; let cool to a warm temperature.
3. Remove plastic lid from can; wipe it off if dusty. Wash top of can with soap and water; rinse well and dry it. Wash can opener. Do not let water get into the can.
4. Pour the warm water into the bottle(s). Use only the scoop that comes with the formula can (8.7 gm). The scoop should be totally dry before scooping out the powdered formula. Add 1 level scoop of the powdered formula for each 2 oz of warm water in the bottle(s). Example: If 8 ounces of water is poured in the bottle, then 4 level scoops of formula should be added.
5. Put nipples and rings on bottle and **shake well**. If feeding immediately, check temperature and then feed. After feeding, throw away formula left in bottle or cup, as this can contain germs.
6. Store filled bottles in refrigerator and ***use within 24 hours***. Put a clean nipple upside down on each bottle. Cover the nipple with a cap and screw on the ring.
7. Do not store can containing the dry powdered formula in the refrigerator. Keep it covered and store in a cool, dry place; avoid temperature extremes. Use can within one month after opening.

Note: *Do not use microwave oven to prepare or to warm formula. Formula heated in the microwave may result in burns.*

Appendix U-1

CONVERSION TABLES AND EQUIVALENTS

I. TABLE OF EQUIVALENTS

3 teaspoon (tsp.)	=	1 Tablespoon (Tbsp.)
2 Tbsp.	=	1 ounce (oz)
8 oz.	=	1 cup (c.)
16 Tbsp.	=	1 c.
2 c.	=	1 pint (pt.)
2 pts.	=	1 quart (qt.)
4 c.	=	1 qt.
4 qts.	=	1 gallon (gal.) = 128 oz.

II. METRIC SYSTEM

A. APPROXIMATE WEIGHTS/MEASURES

20 drops	=	1 milliliter (ml.)
1 ml.	=	1 gram (g.)
1 ml.	=	1 cubic centimeter (cc)
1 tsp.	=	5 ml. = 5 cc = 5 g.
1 Tbsp.	=	15 ml. = 15 cc = 15 g.
1 oz., fluid	=	29.57 ml. = 30 cc
1 cup, fluid	=	240 ml.
1 oz., weight	=	28.35 g. (approx 30)
1 c., weight	=	240 g.
1 pound (lb.)	=	453.6 g.
2.2 lbs.	=	1 kilogram (kg.)
33 ½ oz.	=	1 liter (L.)
1.1 qts.	=	1000 ml = 1 liter

B. WEIGHTS

1 milligram	=	1000 micrograms (mcg)
1 gram (g)	=	1000 mg.
1 kilogram	=	1000 g.

C. CONVERSIONS

To convert ounces to grams multiply by 30.
To convert grams to ounces divide by 30.
To convert pounds to kilograms divide by 2.2.
To convert kilograms to pounds multiply by 2.2.
To convert inches to centimeters multiply by 2.54.

References: Georgia Dietetic Association, Inc., Diet Manual, 4th edition, 1992.

Appendix U-2

APPROXIMATE METRIC AND IMPERIAL EQUIVALENTS

Useful approximate metric and imperial equivalents

1 cm = 0.39 in	1 in = 2.54 cm
1 meter = 1.1 yd.	1 ft = 30.48 cm

To convert centimeters to inches

Divide the length in centimeters by 2.54.

Example: The average newborn infant measures 50.89 cm:

50.89 cm: 2.54 cm/in = 20 in

To convert inches to centimeters

Multiply the length in inches by 2.54

Example: The average newborn infant measures 20 in:

20 in x 2.54 cm/in = 50.8 cm