



**Rhode Island Department of Health  
WIC Program  
Medical Information Form for Infants & Children**

*Note to Health Care Provider:*

*Please print out this form, complete it and give it back to your patient to return to WIC.*

A. Patient Information	
Patient Name:	Date of Birth:
Parent/Guardian Name:	

B. All Infants/Children	Infants/Children < Age 2
Date Obtained:	Birth Weight:
Weight:	Birth Length:
Length/Height:	Gestational age at birth: _____ weeks
# DtaP Immunizations Given to Date:	

C. Laboratory Results
Date Collected:
*Hgb:
*Hct:
Blood Lead:
*Required between 9-12 months and 12-24 months then once yearly (unless value < 11.1 Hgb or < 33% Hct, then required in 6 months).

D. Health/Medical Concerns (including ICD-9 code (s))

E. Patient's Health Care Provider	
Provider Name:	
Signature:	Date:
Address:	Phone: