EXHIBIT 5-II1

# Manual Certification – Infants and Children

FEBURARY 2023

**Date:**_____ **State WIC ID:**_____ **WIC Type**: ☐ Infant ☐ Child

**Certification Type**: ☐ New Certification ☐ Re-Certification ☐ Mid-Certification

## Demographics Information

Last Name: _____ First Name: _____

Birth Date (mm/dd/yyyy): _____ Gender: ☐ Male ☐ Female

**Hispanic or Latino Ethnicity:** ☐ Yes ☐ No

**Race:** ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaska Native

**If American Indian/Alaska Native, please select one of the following:**

☐ Bois Forte ☐ Fond du Lac ☐ Grand Portage ☐ Leech Lake ☐ Lower Sioux ☐ Upper Sioux ☐ White Earth

☐ Mille Lacs Tribe ☐ Red Lake ☐ Mdewakanton ☐ Prairie Island ☐ Other ☐ Participant Declined

| |
|---|
| Insurance Type: ☐ MA ☐ MN Care ☐ None ☐ Other ☐ Private |
| Medical Clinic: |
| Household language: |
| Authorized Representative/Primary Card Holder:<br>Alternate Representative/Proxy 1:<br>Alternate Representative/Proxy 2: |

## Health Information

| | | | |
|---|---|---|---|
| Unknown Birth Criteria: ☐ | Birth Weight:_____<br>Birth Length:_____ | Premature Birth: ☐ Yes ☐ No | Weeks Gestation: |
| Was the infant ever breastfed: ☐ Yes ☐ No ☐ Unknown | | | |
| Breastfeeding Now: ☐ Yes ☐ No If **Yes**, Date Breastfeeding verified: _____<br>If **No**, reason why stopped breastfeeding:_____ | | | |

**Amount of Breastfeeding**: (Infants only – all children are non-breastfeeding in the system)

☐ Fully Breastfeeding ☐ Mostly-Breastfeeding ☐ Some-Breastfeeding ☐ Non-Breastfeeding

If **not** Fully Breastfeeding, Date Supplemental Feeding Began:_____

If Infant, Formula currently using:_____

| | | |
|---|---|---|
| Date Solids were introduced:_____<br>**OR** ☐ Not Applicable | **Requires FP III**: ☐ Yes ☐ No<br>Date verified:_____ | Medical Conditions:<br>☐ Diabetes Mellitus<br>☐ Hypertension/Prehypertenstion |
| Household Smoking: ☐ Yes ☐ No | TV/Viewing (>2 years old): number of hours per day: _____ | |

## Height, Weight, and Blood

| | |
|---|---|
| Measurement Date:_____ | Date for Blood work: _____ |
| Measurement Position: ☐ Recumbent ☐ Standing | Hgb:_____ HCT:_____ |
| Length/Height:_____ inches_____1/8ths | Reason Blood Work not Collected (write note): |
| Weight:_____ lbs _____ ounces | ☐ CPA determined not due<br>☐ Medical ☐ Religious |

## Nutrition Assessment

Results:

## Nutrition Education/Materials Given

NE Topics and Materials Given:

### Referrals

Referrals Given:

## Food Package

Notes:

## Comments

Notes: