Kentucky WIC Proxy Authorization Form

* This form is to be completed, signed, dated and returned along with the completed Registration, Consent and WIC Certification form to your local health department.

I____________________________________, am the woman participant, parent, legal representative, or caretaker for the below minor infant/child (if applicable). I give permission to the person(s) listed as proxies to obtain WIC benefits, purchase WIC approved foods or obtain nutrition education on my behalf or to bring ___________________________________________ to obtain same.

(Name of Infant/Child)
I understand that this person(s) must follow all program rules. This permission includes sharing and obtaining nutritional information. I understand this proxy form is for WIC purposes only and does not signify permission for any other programs or procedures.

Please complete the information below
(See back if additional spaces are needed)

Full name of self (woman participant), infant or child: ____________________________________________

Name(s) of Authorized Proxy Representative(s):

1. ____________________________________________________________
   Relationship to woman participant, infant/child: ______________________________

2. ____________________________________________________________
   Relationship to woman participant, infant/child: ______________________________

3. ____________________________________________________________
   Relationship to woman participant, infant/child: ______________________________

Signature: ____________________________________________ Date: ________________
(Woman participant, Parent, Legal Representative, or Caretaker)

Emergency Contact Phone Number: ____________________________________________

Street Address: ____________________________________________________________

City and Zip Code: __________________________________________________________

Please initial and date if you have reviewed this form at recertification and do not wish to make changes/additions:

Initial: _______ Date: ____________ Initial: _______ Date: ____________ Initial: _______ Date: ____________

Initial: _______ Date: ____________ Initial: _______ Date: ____________ Initial: _______ Date: ____________

Initial: _______ Date: ____________ Initial: _______ Date: ____________ Initial: _______ Date: ____________

Rev.6/2016
Proxy Addendum Section

Name(s) of Authorized Proxy Representative(s):

4. _______________________________________________________________________
   Relationship to woman participant, infant/child: ________________________________

5. _______________________________________________________________________
   Relationship to woman participant, infant/child: ________________________________

6. _______________________________________________________________________
   Relationship to woman participant, infant/child: ________________________________

7. _______________________________________________________________________
   Relationship to woman participant, infant/child: ________________________________

8. _______________________________________________________________________
   Relationship to woman participant, infant/child: ________________________________

Local Health Department use only

Verbal Proxy Authorization

I have informed the woman participant, parent, legal representative, or caretaker of the intent of
this proxy authorization and the consent is valid for the certification period or until there is a
request for change by the woman participant, parent, legal representative, or caretaker.

Name of person giving authorization: ____________________________ Date: _____________

Signature/Title/Date of person obtaining: _________________________ Date: ______________