Kentucky WIC Proxy Authorization Form

(Patient Name: ____)

Place Chart Label Here

(Patient ID: ______________________________ HID/LOC: ___________)

** 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 <u>do not</u> wish to make changes/additions:

Initial:_________ **Date:**___________ **Initial:**__________ **Date:**___________ **Initial:**__________ **Date:**___________

Initial:_________ **Date:**___________ **Initial:**__________ **Date:**___________ **Initial:**__________ **Date:**___________

Initial:_________ **Date:**___________ **Initial:**__________ **Date:**___________ **Initial:**__________ **Date:**___________

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: ____________