Women, Infants, and Children (WIC) Supplemental Nutrition Program California
Department of Public Health, WIC Division
3901 Lennane Drive
Sacramento, CA 95834
1-800-852-5770 ~ Send form to:WIC@CDPH.CA.GOV

Verification of Participation in the WIC Program

I understand that my choice to sign or not to sign this form will NOT affect my eligibility for, or participation in the WIC Program, or the eligibility for or participation in the WIC Program of any children for whom I am legally responsible.

I _____ am requesting my WIC records. These records are for me **and/or** my child (ren).

Name of Participant: _____ Date of Birth: _____

My relationship to the WIC participant listed above is: □Self □Parent / Legal Guardian of child on WIC

I am requesting WIC records for the following children:
Name of Minor: _____ Date of Birth: _____
Name of Minor: _____ Date of Birth: _____
Name of Minor: _____ Date of Birth: _____
Name of Minor: _____ Date of Birth: _____

The address I used while on WIC is:

_____
_____
_____

This information is for the following purpose(s):

_____
_____
_____

I understand that this agreement provides exclusively for the one-time disclosure of WIC information in the manner described above. No other disclosures shall be made without my prior written consent.

_____ _____ _____
Name of Participant/Parent/Guardian (**Printed)** **Signature** Date

_____
Current mailing address of Participant/Parent/Guardian

_____
Current email address for delivery of letter

***MANDATORY*; Attach a photocopy of your state, federal, or other form of identification that includes your full name.**

PICTURE I.D. HERE

Last Revised 02/19/21