

# Prescription for Your Healthy Child

NAME \_\_\_\_\_

DATE \_\_\_\_\_

## Prescription for diet change:

- |   |  |
|---|--|
| <input type="checkbox"/> Offer low-fat milk only              | <input type="checkbox"/> Serve child-size amounts of food            |
| <input type="checkbox"/> Serve 2-3 cups of low-fat milk a day | <input type="checkbox"/> Offer fruit instead of candy or cookies     |
| <input type="checkbox"/> Wean from bottle to cup              | <input type="checkbox"/> Offer water instead of soda or juice drinks |
| <input type="checkbox"/> Offer more fruits and vegetables     |  |

## Prescription for activity change:

- |   |   |
|---|---|
| <input type="checkbox"/> Schedule active play for at least _____minutes daily | <input type="checkbox"/> Watch TV no more than _____minutes daily |
|---|---|

**Other:** \_\_\_\_\_

- Talk with your WIC counselor for personalized help on feeding your child

\_\_\_\_\_ MD

Take this prescription form with you to your local WIC office. **1-800-WIC-1007**

