



**Consent of Parent or Legal Guardian for Alternate Authorized Representative Form**

Local Agency: \_\_\_\_\_ Site: \_\_\_\_\_ Date: \_\_\_\_\_

Participant's Name: \_\_\_\_\_ WIC ID #: \_\_\_\_\_

Authorized Representative (AR): \_\_\_\_\_

Relationship: \_\_\_\_\_

(mother, father, legal guardian, or temporary caretaker, etc.)

Summary of Alternate Authorized Representative information:

The above Authorized Representative (AR) has provided verbal permission to the named individual to facilitate subsequent assessment and enrollment of the named child (children) in the District of Columbia Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Program as an active participant on their behalf. They have certified that this individual is at least 18 years old.

The AR has been completely informed of the services to be provided to the infant or child by the DC WIC Program, namely: medical services which may include taking a blood sample from the finger to test for iron in the blood; nutrition assessment; nutrition education and/or counseling; and the provision of checks for food. The AR has provided fully consent.

The AR has certified that the information provided is correct to the best of their knowledge. The AR accepts that intentionally making a false or misleading statement, intentionally misrepresenting, concealing or withholding facts may result in paying the WIC State Agency in cash the value of food benefits improperly issued to them and may subject them to criminal prosecution under State and Federal Law.

The AR understands that they are responsible for all actions and Program violations that may be performed by the selected Alternate Authorized Representative.

Name of selected Alternate Authorized Representative: \_\_\_\_\_

Relationship to participant: \_\_\_\_\_

\_\_\_\_\_  
Name and Signature of Local Agency Staff

\_\_\_\_\_  
Date