

**AT RISK OF SHORT STATURE**

**(121A)**

**SHORT STATURE**

**(121B)**

<b>PARTICIPANT TYPE.....</b>	<b>INFANTS, CHILDREN</b>
<b>HIGH RISK.....</b>	<b>No</b>

**RISK DESCRIPTION:**

**DEFINITION OF AT RISK OF SHORT STATURE:**

- Birth to 2 years: > 2.3<sup>rd</sup> and ≤ 5<sup>th</sup> percentile length-for-age
- 2-5 years: > 5<sup>th</sup> and ≤ 10<sup>th</sup> percentile stature-for-age

**DEFINITION OF SHORT STATURE:**

- Birth to 2 years: ≤ 2.3<sup>rd</sup> percentile length-for-age
- 2-5 years: ≤ 5<sup>th</sup> percentile stature-for-age

Notes: For children birth to 2 years of age, these risks are based on the 2006 World Health Organization international growth standards. For children 2-5 years of age, these risks are based on the 2000 National Center for Health Statistics/Centers for Disease Control and Prevention age and sex specific growth charts.

For premature infants and children up to 2 years of age with a history of prematurity, assignment of this risk criterion is based on adjusted gestational age.

**ASK ABOUT:**

- Birth status including birth weight and prematurity
- Growth history
- Parental stature
- Chronic medical conditions interfering with nutrient absorption or metabolism including but not limited to endocrine disturbances, inborn errors of metabolism, chromosomal defects, Fetal Alcohol Syndrome, chronic systemic diseases
- Medications that may interfere with intake, appetite, or nutrient absorption
- Typical intake pattern
- Family and household environment including social and psychological environment (e.g., chaotic, highly distractible, disorganized), depressed parents or caregivers, number of caregivers responsible for food preparation and feeding, parental substance use or abuse
- Access to ongoing health care and attendance at well child visits
- Family, religious or cultural issues affecting child feeding practices
- The child’s developmental feeding skills in relationship to child’s age
- Food security status of the household

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## NUTRITION COUNSELING/EDUCATION TOPICS:

- Consider the overall growth pattern and parental height before framing your messages. This could be the normal growth pattern for this infant or child. It is important not to create undue concern.
- Reinforce what the parent is doing right.
- Reassure the parents that WIC will continue to monitor the child's growth.
- Review relevant age-appropriate feeding guidelines including:
  - Appropriate frequency of feedings (breastfeeding and formula)
  - Proper formula dilution and sanitary formula preparation
  - Introduction of solid foods when developmentally ready (for premature infants, remember to consider adjusted age and developmental readiness)
  - Parent's awareness of hunger and satiety cues
  - Provide adequate number of servings from each food group.
  - Provide age-appropriate serving sizes and textures of food.
  - Discuss strategies to increase the caloric density of the diet including adding nuts, dried fruit, dry milk powder, grated cheese and other ingredients.
  - Replace calorie-free foods with nutrient-dense food choices that provide calories.
  - Offer regular meals and snacks. Consider five or six small meals rather than two or three large meals.
  - Discuss the division of responsibility in feeding. Encourage the parent to allow the child to decide how much to eat and to trust their child to grow.
  - Identify ways to foster a pleasant mealtime environment and to limit distractions during meals and snacks.
  - Identify strategies for sharing information with all caregivers responsible for feeding and food preparation.

## POSSIBLE REFERRALS:

- If subsequent length rechecks continue to move downward on the growth chart, refer the child to their primary care provider for further evaluation.
- If the child is not receiving well child care or keeping appointments, refer the child (if on medical assistance) to Health Tracks (<http://www.nd.gov/dhs/services/medicalserv/health-tracks/>), the local public health department, or primary care providers in the community.
- If access to sufficient food is a concern, refer to other community resources for food assistance (SNAP, food pantries, etc.).
- If the household and family situation is so disordered that establishing a normal feeding relationship is unlikely, refer the family to local public health department, a feeding team that works with children, or social service agency.
- If parental substance use or abuse is a concern, refer to community resources and treatment centers.
- If the child appears to have developmental delays, refer the family to the Right Track Program for early intervention services (<http://www.nd.gov/dhs/services/disabilities/earlyintervention/parent-info/right-track.html>).