

**REQUIRED Medical Documentation for WIC Formula and Approved WIC Foods
Infants (birth up to 12 months)**

Patient's Name _____ Birthdate _____

Patient's Parent/Guardian/Caretaker Name _____

INFANTS

1. Qualifying medical condition(s):

Qualifying conditions include, but are not limited to:

- Premature birth
- Low birth weight
- Gastrointestinal disorders
- Failure to thrive
- Immune system disorders
- Malabsorption syndromes
- Severe food allergies that require an elemental formula
- Inborn errors of metabolism and metabolic disorders
- Diseases and medical conditions that impair ingestion, digestion, absorption or the utilization of nutrients that could adversely affect the participant's nutrition status

Non-qualifying conditions:

- Formula or food intolerance
- Patient/parent preference
- Food allergy to lactose, sucrose, milk protein or soy protein not requiring an elemental formula

2. Name of WIC Exempt formula prescription:

Prescribed amount per day: _____

Physical Form: Powder Concentrate Ready to Use

Special instructions for preparation and use: _____

3. 6-11 months of age *only* WIC allowed foods (please select all that apply):

- Infant cereal
- Infant food fruits /vegetables

4. Length of use: 1 month 3 months 6 months 12months

Other _____

SIGNATURE (Health Care Provider) :

Date:

Printed Name (Health Care Provider):

Medical Office/ Clinic:

Telephone:

Address:

WIC Staff Use Only:

**REQUIRED Medical Documentation for WIC Formula and Approved WIC Foods
Children (1 up to 5 years)**

Patient's Name _____ Birthdate _____

Patient's Parent/Guardian/Caretaker Name _____

CHILDREN

1. Qualifying medical condition(s):

Qualifying conditions include, but are not limited to:

- Premature birth
- Low birth weight
- Gastrointestinal disorders
- Failure to thrive
- Immune system disorders
- Malabsorption syndromes
- Severe food allergies that require an elemental formula
- Inborn errors of metabolism and metabolic disorders
- Diseases and medical conditions that impair ingestion, digestion, absorption or the utilization of nutrients that could adversely affect the participant's nutrition status

Non-qualifying conditions:

- Food intolerance
- Patient preference
- Management of body weight without underlying medical condition

2. Name of WIC standard formula/exempt formula/medical food prescription:

Prescribed amount per day: _____

Physical Form: Powder Concentrate Ready to Use

Special instructions for preparation and use: _____

3. WIC allowed foods (please select all that apply):

<input type="checkbox"/> <i>No Foods</i>	<input type="checkbox"/> <i>All Foods EXCEPT (check all that apply):</i>	
<input type="checkbox"/> <i>All Foods</i> (Children 12 -24 months receive Whole Milk only)	<input type="checkbox"/> Breakfast cereal	<input type="checkbox"/> 100% juice
<input type="checkbox"/> <i>All Foods</i> (Children >24 months receive 2%, 1% or Skim Milk only)	<input type="checkbox"/> Fresh/frozen fruits and vegetables	<input type="checkbox"/> Whole wheat bread or other whole grains
	<input type="checkbox"/> Eggs	<input type="checkbox"/> Beans or peanut butter (>2 yrs)
	<input type="checkbox"/> Cheese	
	<input type="checkbox"/> Milk	

Whole Milk for Children ≥ 24 months
Children ≥ 24months who have a qualifying medical condition may receive whole milk. (Formula or medical food is not required to receive Whole Milk.)

Soy Milk for Children ≥ 12 months
Children ≥ 12 months who have a qualifying medical condition OR one of the conditions listed below may receive Soy Milk:
 Milk allergy Severe lactose maldigestion Vegan diet
(Formula or medical food is not required to receive Soy Milk.)

4. Length of use: 1 month 3 months 6 months 12 months (maximum approval)

Other _____

SIGNATURE (Health Care Provider) : _____ Date: _____

Printed Name (Health Care Provider): _____

Medical Office/ Clinic: _____ Telephone: _____

Address: _____

WIC Staff Use Only: