

**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):** \_\_\_\_\_

**2. Name of WIC Exempt formula prescription:** \_\_\_\_\_

Prescribed amount per day: \_\_\_\_\_ oz/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

**Qualifying conditions include, but are not limited to:**

- Premature birth
- Low birth weight
- Failure to thrive
- Inborn errors of metabolism and metabolic disorders
- Gastrointestinal disorders
- Malabsorption syndromes
- Immune system disorders
- Severe food allergies that require an elemental formula
- 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
- Food allergy to lactose, sucrose, milk protein or soy protein not requiring an elemental formula
- Patient/parent preference

**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):** \_\_\_\_\_

**2. Name of WIC 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>All foods</i>                          | <input type="checkbox"/> Breakfast cereal                      | <input type="checkbox"/> Whole wheat bread or            |
| <input type="checkbox"/> <i>No foods</i>                           | <input type="checkbox"/> Fresh fruits and vegetables           | other whole grains                                       |
| <input type="checkbox"/> <i>All EXCEPT (check all that apply):</i> | <input type="checkbox"/> Milk (<2yrs whole, >2yrs reduced fat) | <input type="checkbox"/> 100% juice                      |
|  | <input type="checkbox"/> Eggs                                  | <input type="checkbox"/> Beans or peanut butter (>2 yrs) |

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

**Qualifying conditions include, but are not limited to:**

- Premature birth
- Low birth weight
- Failure to thrive
- Inborn errors of metabolism and metabolic disorders
- Gastrointestinal disorders
- Malabsorption syndromes
- Immune system disorders
- Severe food allergies that require an elemental formula
- 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
- Management of body weight without underlying medical condition
- Patient preference

**SIGNATURE** (Health Care Provider) : \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name (Health Care Provider): \_\_\_\_\_

Medical Office/ Clinic: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

**WIC Staff Use Only:**