REQUIRED MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS - CHILDREN (1 UP TO 5 YEARS)

State Form 55323 (R3 / 3-17)
INDIANA STATE DEPARTMENT OF HEALTH
INDIANA WOMEN, INFANTS, & CHILDREN PROGRAM (WIC)

Patient's Name: _____ **Birthdate** *(mm/dd/yyyy)*: _____

Patient's Parent/Guardian/Caretaker Name: _____

PLEASE COMPLETE EACH SECTION FOR YOUR CHILD PATIENT.

1. Qualifying conditions include, but are not limited to: *(Check all that apply.)*

- ☐ Premature birth
- ☐ Low birth weight
- ☐ Gastrointestinal disorders
- ☐ Failure to thrive
- ☐ Immune system disorder
- ☐ 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

2. Name of WIC standard formula/exempt infant formula/WIC-eligible nutritionals prescription:

_____

Prescribed amount per day: _____

Physical Form: ☐ Powder ☐ Concentrate ☐ Ready to Use

Special instructions for preparation and use: _____

3. Allowed WIC foods *(Please check appropriate boxes.)*

☐ ***No Foods***	☐ ***All Foods EXCEPT (check all that apply):***
☐ ***All foods*** (Children 12-24 months receive Whole Milk only.) (Children >24 months receive 1% or Skim Milk only.)	☐ Breakfast cereal ☐ Milk ☐ Fresh/frozen fruits and vegetable ☐ 100% juice ☐ Eggs ☐ Whole wheat bread or other whole grains ☐ Cheese ☐ Beans or peanut butter (>2yrs) ☐ Yogurt

The following choices may be provided for the specified age group for patients with a qualifying condition. Please check all that apply. A length of use is still required when ordering these items. (Formula or WIC-eligible nutritionals are not required for the patient to receive these items.)

All ages	☐ Infant cereal (in place of breakfast cereal)			☐ Pureed fruits and vegetables (in place of fresh/frozen fruits and vegetables)		
Child 12-24 month	☐ 2% Milk	☐ 1% Milk	☐ Skim Milk	***Child ≥ 24 month***	☐ Whole Milk	☐ 2% Milk
All ages	☐ Soy Milk	**NOTE: Soy Milk may be provided for Children who have (1) a qualified medical condition listed above, or (2) other condition which includes but is not limited to one of the following** *(Please check all that apply.)*:				
		☐ **Milk allergy**		☐ **Severe lactose maldigestion**		☐ **Vegan diet**

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

Other: _____

SIGNATURE *(Health Care Provider)*: _____ Date *(mm/dd/yyyy)*: _____

Printed Name *(Health Care Provider)*: _____

Medical Office/Clinic: _____ Telephone: _____

Address *(number and street, city, state, and ZIP code)*: _____

WIC Staff Use Only: Non-qualifying conditions:

- food intolerance
- Management of body weight with no underlying medical condition
- Patient preference

This institution is an equal opportunity provider.