Expires: _____
(For WIC use only.)

ND WIC Medical Documentation Form

The WIC Program requires a medical diagnosis to provide a medical formula. All requests are subject to WIC approval. Complete this form, then fax to _____, email to _____, or have the participant return it to their local WIC office.

Participant's Name: _____ **Date of Birth:** _____

Parent/Guardian's Name: _____

Medical Formula requested: _____
Not Allowed: Enfamil Infant, ProSobee, A.R., Gentlease, or Reguline; Gerber formulas; store brand formulas; Similac Pro formulas

Medical Diagnosis: (Not acceptable diagnoses - formula intolerance, spitting up, colic, or personal preference)

- ☐ Cow's milk protein allergy/sensitivity
- ☐ Failure to thrive
- ☐ Malabsorption syndromes
- ☐ Gastroesophageal reflux disease (GERD)
- ☐ Developmental sensory/motor delays
- ☐ Inborn errors of metabolism/metabolic disorders
- ☐ Prematurity/low birth weight
- ☐ Gastrointestinal disorders
- ☐ Severe food allergies
- ☐ Other medical diagnosis: _____

Time needed: _____ months OR ☐ Until 1 year of age

Prescribed amount: ☐ Full Amount Allowed OR _____ oz/day

Preparation/feeding instructions: _____

☐ **Formula only (includes standard formula) –** Do not provide any supplemental foods.

☐ For children (1-4 years) receiving formula, provide infant cereal or baby food fruits/vegetables.

☐ For children (2-4 years) or women **receiving formula**, provide whole milk.

WIC Foods – Choose one of the options below. If left blank, the WIC Nutritionist/Dietitian will determine foods issued.

☐ **Request WIC Nutritionist/Dietitian to determine foods issued.**

☐ **Omit the following WIC foods.** (All WIC foods will be provided unless indicated below.)

_____

Standard Food Packages: **Infants:** (0-5mo) formula only; (6-11 months) infant cereal, baby food fruits/vegetables and formula
Children (1-4 years) and **Women:** milk, cheese, yogurt, juice, fruits/vegetables, whole grains, eggs, beans, cereal, peanut butter

Signature of Health Care Provider: _____ **Date:** _____

Health Care Provider's Name: _____ ☐ MD ☐ DO ☐ NP ☐ PA

Clinic/Address: _____

Phone Number: _____ **Fax Number:** _____

For more information or help in completing this form: Contact _____at _____.