

## INFANTS

### Illinois WIC Formula and Medical Nutritional Prescription

This form must be completed by a medical provider, in its entirety, to receive Medically Prescribed Formula.

<b>Patient Name</b> (Last) _____ (First) _____		<b>Birthdate:</b> _____/_____/____	
<b>Parent / Caregiver</b> (Last) _____ (First) _____			
<b>1. PRESCRIBED FORMULA – Choose One</b>			
<b>Infant (0-11 months of age)</b>			
6 months or older no foods: <input type="checkbox"/> Enfamil Infant <input type="checkbox"/> Enfamil Gentlease <input type="checkbox"/> Enfamil ProSobee <input type="checkbox"/> Enfamil AR <input type="checkbox"/> Enfamil Reguline	<div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> Enfamil NeuroPro Enfacare (pwd) <input type="checkbox"/> Similac Neosure (pwd) <input type="checkbox"/> ready-to-feed <input type="checkbox"/> Alimentum (pwd) <input type="checkbox"/> ready-to-feed <input type="checkbox"/> Nutramigen w/Probiotic LGG</div><div><input type="checkbox"/> Pregestimil <input type="checkbox"/> Similac PM 60/40 <input type="checkbox"/> Neocate Infant DHA/ARA <input type="checkbox"/> Neocate Syneo Infant <input type="checkbox"/> EleCare DHA/ARA <input type="checkbox"/> PurAmino DHA/ARA</div></div>		
<b>2. FOOD PRESCRIPTION</b>			
<b>Infant (0-11 months of age) – Choose One</b>			
<input type="checkbox"/> Formula <b><u>ONLY</u></b> (no foods during duration of this prescription)  <input type="checkbox"/> Formula and *WIC foods beginning at 6 months  *WIC foods may include: Infant cereal      Infant fruits/vegetables (jarred)      Fresh fruits/vegetables (9-11 months only)			
<b>3. DIAGNOSIS, AMOUNT, DURATION</b>			
WIC Federal Regulations <b><u>do not allow the following conditions</u></b> for issuance of medical formulas: Managing body weight, growth concerns, unconfirmed allergies, lactose intolerance, or intolerance symptoms. Please specify the underlying medical condition(s).			
<input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cleft Lip / Palate <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Eosinophilic GI	<input type="checkbox"/> Gastroesophageal Reflux <input type="checkbox"/> Intestinal Malabsorption <input type="checkbox"/> Prematurity (up to 2 years) <input type="checkbox"/> Tube Fed NPO <input type="checkbox"/> Tube Fed	<input type="checkbox"/> Confirmed Allergy (specify): _____	<input type="checkbox"/> Other Medical Diagnosis (specify): _____
<b>Prescribed Amount:</b> <input type="checkbox"/> Maximum amount WIC provides <b>OR</b> _____ Ounces per day <b>OR</b> _____ Cans per day			
<b>Duration:</b> <input type="checkbox"/> 1 month <input type="checkbox"/> 2 months <input type="checkbox"/> 3 months <input type="checkbox"/> 4 months <input type="checkbox"/> 5 months <input type="checkbox"/> 6 months			
<b>4. HEALTH CARE PROVIDER INFORMATION</b>			
Health Care Provider Signature: _____ Date Signed: _____ (Physician, Physician Assistant or Advanced Practice Nurse Practitioner)			
Printed Name of Health Care Provider: _____			
Medical Office/Clinic: _____			
Address: _____ Phone: _____			
<i>This institution is an equal opportunity provider.</i>			

## CHILDREN

### Illinois WIC Formula and Medical Nutritional Prescription

This form must be completed by a medical provider, in its entirety, to receive Medically Prescribed Formula.

<b>Patient Name</b> (Last) _____ (First) _____	<b>Birthdate:</b> _____/_____/_____
<b>Parent / Caregiver</b> (Last) _____ (First) _____	

#### 1. PRESCRIBED FORMULA – Choose One

##### Children (1 to 4 years)

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Enfamil Infant    | <input type="checkbox"/> Nutramigen w/Probiotic LGG | <input type="checkbox"/> Neocate Junior              | PediaSure 1.5 Cal                                  |
| <input type="checkbox"/> Enfamil Gentlease | <input type="checkbox"/> Pregestimil                | <input type="checkbox"/> Neocate Junior w/Prebiotics | <input type="checkbox"/> without fiber             |
| <input type="checkbox"/> Enfamil ProSobee  | EleCare Jr  | Nutren Junior  | <input type="checkbox"/> with fiber                |
| <input type="checkbox"/> Enfamil AR        | <input type="checkbox"/> unflavored (pwd)           | <input type="checkbox"/> without fiber               | <input type="checkbox"/> PediaSure Peptide 1.0 Cal |
| <input type="checkbox"/> Enfamil Reguline  | <input type="checkbox"/> flavored (pwd)             | <input type="checkbox"/> with fiber                  | Peptamen Junior                                    |
| <input type="checkbox"/> Alimentum (pwd)   | <input type="checkbox"/> PurAmino DHA/ARA           | PediaSure  | <input type="checkbox"/> without fiber             |
| <input type="checkbox"/> ready-to-feed     | <input type="checkbox"/> Neocate Splash             | <input type="checkbox"/> without fiber               | <input type="checkbox"/> with fiber                |
|  |   | <input type="checkbox"/> with fiber                  | <input type="checkbox"/> with Prebio               |

#### 2. FOOD PRESCRIPTION

##### Children (1 to 4 years) – Choose One

- ☐ Formula **ONLY** (no foods during duration of the prescription)
- ☐ Formula and \*WIC foods
- ☐ Formula, \*WIC foods and jarred infant fruits/vegetables (in place of fresh fruits/vegetables)

\*WIC foods may include the following:

Cereal, whole-wheat bread/tortillas/pasta/bulgur/brown rice/oatmeal, milk, cheese, yogurt, tofu; peanut butter, beans, eggs, 100% juice, fruits/vegetables

#### 3. DIAGNOSIS, AMOUNT, DURATION

WIC Federal Regulations **do not allow the following conditions** for issuance of medical formulas: Managing body weight, growth concerns, unconfirmed allergies, lactose intolerance, or intolerance symptoms. Please specify the underlying medical condition(s).

<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Gastroesophageal Reflux	<input type="checkbox"/> Confirmed Allergy	<input type="checkbox"/> Other Medical Diagnosis
<input type="checkbox"/> Cleft Lip / Palate	<input type="checkbox"/> Intestinal Malabsorption	(specify): _____	(specify): _____
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Prematurity (up to 2 years)		
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Tube Fed NPO		
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Tube Fed		
<input type="checkbox"/> Eosinophilic GI			

**Prescribed Amount:** ☐ Maximum amount WIC provides **OR** \_\_\_\_\_ Ounces/day **OR** \_\_\_\_\_ Cans/day

**Duration:** ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

#### 4. HEALTH CARE PROVIDER INFORMATION

Health Care Provider Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
(Physician, Physician Assistant or Advanced Practice Nurse Practitioner)

Printed Name of Health Care Provider: \_\_\_\_\_

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

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

*This institution is an equal opportunity provider.*