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.

Patient Name (Last) (First)	**Birthdate:**
Parent / Caregiver (Last) (First)	

1. PRESCRIBED FORMULA – Choose One

Infant (0-11 months of age)

6 months or older no foods:

- □ Enfamil Infant
- □ Enfamil Gentlease
- □ Enfamil ProSobee
- □ Enfamil AR
- □ Enfamil Reguline
- □ Enfamil NeuroPro Enfacare (pwd)
- □ Similac Neosure (pwd)
  - □ ready-to-feed
- □ Alimentum (pwd)
  - □ ready-to-feed
- □ Nutramigen w/Probiotic LGG
- □ Pregestimil
- □ Similac PM 60/40
- □ Neocate Infant DHA/ARA
- □ Neocate Syneo Infant
- □ EleCare DHA/ARA
- □ PurAmino DHA/ARA

2. FOOD PRESCRIPTION

Infant (0-11 months of age) – Choose One

□ Formula **ONLY** (no foods during duration of this prescription)

□ 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)

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).

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

Prescribed Amount: ☐ Maximum amount WIC provides **OR** _____Ounces per day **OR** _____ Cans per 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.

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.

Patient Name (Last) (First)	**Birthdate:**
Parent / Caregiver (Last) (First)	

1. PRESCRIBED FORMULA – Choose One

Children (1 to 4 years)

□ Enfamil Infant
□ Enfamil Gentlease
□ Enfamil ProSobee
□ Enfamil AR
□ Enfamil Reguline
□ Alimentum (pwd)
  □ ready-to-feed

□ Nutramigen w/Probiotic LGG
□ Pregestimil

EleCare Jr
  □ unflavored (pwd)
  □ flavored (pwd)

□ PurAmino DHA/ARA
□ Neocate Splash

□ Neocate Junior
□ Neocate Junior w/Prebiotics

Nutren Junior
  □ without fiber
  □ with fiber

PediaSure
  □ without fiber
  □ with fiber

PediaSure 1.5 Cal
  □ without fiber
  □ with fiber

□ PediaSure Peptide 1.0 Cal

Peptamen Junior
  □ without fiber
  □ with fiber
  □ 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).

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

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.