

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 <u>ONLY</u> (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 <u>do not allow the following conditions</u> 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: _____		
<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.

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

1. PRESCRIBED FORMULA – Choose One

Children (1 to 4 years)

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

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