INFANTS

Illinois WIC Formula and Medical Nutritional Prescription

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

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

Measurement Date:	**Length:**	**Weight:**	**Birth Weight/Length:**

1. PRESCRIBED FORMULA – Choose One

Infant (0-11 months of age)

6 months or older no foods:

Enfamil (pwd):

□ Infant □ AR

□ Gentlease □ Reguline

□ ProSobee

□ Enfamil NeuroPro Enfacare (pwd)

□ Similac NeoSure (pwd)

□ ready-to-feed*

□ Alimentum (pwd)

□ ready-to-feed*

□ Nutramigen w/Probiotic LGG (pwd)

□ ready-to-feed*

*Ready-to-feed must meet Federal Requirements for issuance

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), Fruits/vegetables (when applicable)

3. DIAGNOSIS, AMOUNT, DURATION

NOT ALLOWED:

- **Non-Specific Symptoms or Diagnoses** include colic, constipation, diarrhea, spitting up, picky eater, fussiness, gas, etc.
- **Non-Qualifying Conditions** include those solely for enhancing nutrient intake, managing body weight, growth concerns, unconfirmed allergies, lactose intolerance, intolerance symptoms, or caregiver preference.

ALLOWED:

Qualifying Medical Conditions include specific diagnosed disorders, diseases and medical conditions that impair the ingestion, digestion, absorption, or utilization of nutrients that could adversely affect nutrition status.

□ Low birth weight <5 lbs. 8 oz. □ Preterm/early delivery ≤38 weeks □ Developmental Delay	□ Gastroesophageal Reflux □ Eosinophilic GI □ Malabsorption Syndromes	□ Food Allergy (Specify):	□ Other Qualifying Medical Condition (Specify):

Prescribed Amount: □ Maximum amount WIC provides **OR** □ Less than WIC provides _____ amount/day

Duration: □ 1 month □ 2 months □ 3 months □ 4 months □ 5 months □ 6 months

4. HEALTH CARE PROVIDER INFORMATION

Health Care Provider (Physician, Physician Assistant or Advanced Practice Nurse Practitioner)
Signature:

Date:

Phone:

Fax:

Printed Name: Medical Office:

Address:

This institution is an equal opportunity provider.

July 2025

Reset Form

CHILDREN

Illinois WIC Formula and Medical Nutritional Prescription

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

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

Measurement Date:	**Length/Height:**	**Weight:**	**Birth Weight/Length:**

1. PRESCRIBED FORMULA – Choose One

Children (1 to 4 years)

Enfamil (pwd):
□ Infant □ AR
□ Gentlease □ Reguline
□ ProSobee

□ Alimentum (pwd)
□ ready-to-feed*

□ Nutramigen Probiotic LGG (pwd)
□ ready-to-feed*

PediaSure
□ without fiber
□ with fiber

*Ready-to-feed must meet Federal Requirements for issuance

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 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

NOT ALLOWED:

- **Non-Specific Symptoms or Diagnoses** include colic, constipation, diarrhea, spitting up, picky eater, fussiness, gas, etc.
- **Non-Qualifying Conditions** include those solely for enhancing nutrient intake, managing body weight, growth concerns, unconfirmed allergies, lactose intolerance, intolerance symptoms, or caregiver preference.

ALLOWED:
Qualifying Medical Conditions include specific diagnosed disorders, diseases and medical conditions that impair the ingestion, digestion, absorption, or utilization of nutrients that could adversely affect nutrition status.

□ Prematurity (up to 2 years) □ Developmental Delay	□ Gastroesophageal Reflux □ Eosinophilic GI □ Malabsorption Syndromes	□ Food Allergy (Specify):	□ Other Qualifying Medical Condition (Specify):

Prescribed Amount: □ Maximum amount WIC provides **OR** □ Less than WIC provides _____ amount/day

Duration: □ 1 month □ 2 months □ 3 months □ 4 months □ 5 months □ 6 months

4. HEALTH CARE PROVIDER INFORMATION

Health Care Provider (Physician, Physician Assistant or Advanced Practice Nurse Practitioner)
Signature:

Date:
Phone:
Fax:

Printed Name: Medical Office:

Address:

This institution is an equal opportunity provider.

Reset Form