

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)			
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> Contract Formula Similac Advance, Total Comfort, Soy Isomil, Sensitive</div> <div style="width: 50%;"><input type="checkbox"/> Similac NeoSure <input type="checkbox"/> ready-to-feed* <input type="checkbox"/> Enfamil NeuroPro Enfacare</div> <div style="width: 50%;"><input type="checkbox"/> Alimentum <input type="checkbox"/> ready-to-feed*</div> <div style="width: 50%;"><input type="checkbox"/> Nutramigen w/Probiotic LGG <input type="checkbox"/> ready-to-feed*</div> </div> <p style="text-align: center; font-size: small;">*Powder is standard issuance, ready-to-feed must meet Federal Requirements for issuance</p>			
2. FOOD PRESCRIPTION			
Infant (6-11 months of age)			
WIC foods will begin at 6 months unless otherwise indicated below: <input type="checkbox"/> No WIC foods, Formula <u>ONLY</u> WIC Foods may include Infant Cereal, Fruits/Vegetables Jarred and/or Fresh, Frozen, Canned			
3. DIAGNOSIS, AMOUNT, DURATION			
NOT ALLOWED: <ul style="list-style-type: none"> 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.			
<input type="checkbox"/> Low birth weight <5 lbs. 8 oz. <input type="checkbox"/> Preterm/early delivery ≤38 weeks <input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Gastroesophageal Reflux <input type="checkbox"/> Eosinophilic GI <input type="checkbox"/> Malabsorption Syndromes	<input type="checkbox"/> Food Allergy (Specify): _____	<input type="checkbox"/> Other Qualifying Medical Condition (Specify): _____
Prescribed Amount: <input type="checkbox"/> Maximum amount WIC provides <u>OR</u> <input type="checkbox"/> Less than WIC provides _____ amount/day Duration: <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			
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.			

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)			
<input type="checkbox"/> Contract Formula Similac Advance, Total Comfort, Soy Isomil, Sensitive	<input type="checkbox"/> Alimentum <input type="checkbox"/> ready-to-feed*	<input type="checkbox"/> Nutramigen Probiotic LGG <input type="checkbox"/> ready-to-feed*	PediaSure <input type="checkbox"/> without fiber <input type="checkbox"/> with fiber
<small>*Powder form is standard issuance, ready-to-feed must meet Federal Requirements for issuance</small>			
2. FOOD PRESCRIPTION			
Children (1 to 4 years)			
WIC foods will be provided unless otherwise indicated below: <input type="checkbox"/> No WIC foods, Formula <u>ONLY</u> Jarred Infant fruits/vegetables in lieu of fresh, frozen or canned: <input type="checkbox"/> WIC Foods with Jarred Infant Foods WIC foods may include: Cereal, Whole Grains, Milk, Cheese, Yogurt, Tofu, Peanut Butter, Beans, Eggs, 100% juice, Fruits & Vegetables			
3. DIAGNOSIS, AMOUNT, DURATION			
NOT ALLOWED: <ul style="list-style-type: none"> 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.			
<input type="checkbox"/> Prematurity (up to 2 years) <input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Gastroesophageal Reflux <input type="checkbox"/> Eosinophilic GI <input type="checkbox"/> Malabsorption Syndromes	<input type="checkbox"/> Food Allergy (Specify): _____	<input type="checkbox"/> Other Qualifying Medical Condition (Specify): _____
Prescribed Amount:	<input type="checkbox"/> Maximum amount WIC provides <u>OR</u> <input type="checkbox"/> Less than WIC provides _____ amount/day		
Duration:	<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		
4. HEALTH CARE PROVIDER INFORMATION			
Health Care Provider (Physician, Physician Assistant or Advanced Practice Nurse Practitioner)		Date: _____	
Signature: _____		Phone: _____	
		Fax: _____	
Printed Name: _____		Medical Office: _____	
Address: _____			
<i>This institution is an equal opportunity provider.</i>			