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)

□ Contract Formula
Similac Advance, Total Comfort, Soy Isomil, Sensitive

□ Similac NeoSure
□ ready-to-feed*

□ Alimentum
□ ready-to-feed*

□ Nutramigen w/Probiotic LGG
□ ready-to-feed*

□ Enfamil NeuroPro Enfacare

*Powder is standard issuance, ready-to-feed must meet Federal Requirements for issuance

2. FOOD PRESCRIPTION

Infant (6-11 months of age)

WIC foods will begin at 6 months unless otherwise indicated below:

□ No WIC foods, Formula **ONLY**

WIC Foods may include Infant Cereal, Fruits/Vegetables Jarred and/or Fresh, Frozen, Canned

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.

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)

□ Contract Formula
Similac Advance, Total Comfort, Soy Isomil, Sensitive

□ Alimentum
□ ready-to-feed*

□ Nutramigen Probiotic LGG
□ ready-to-feed*

PediaSure
□ without fiber
□ with fiber

*Powder form is standard issuance, ready-to-feed must meet Federal Requirements for issuance

2. FOOD PRESCRIPTION

Children (1 to 4 years)

WIC foods will be provided unless otherwise indicated below:

□ No WIC foods, Formula **ONLY**

Jarred Infant fruits/vegetables in lieu of fresh, frozen or canned:

□ 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:

- **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.