

**REQUIRED Medical Documentation for WIC Formula and Approved WIC Foods
Pregnant, Breastfeeding and Nonbreastfeeding PostPartum Women**

Patient's Name _____ Birthdate _____

Minor Patient's Parent/Guardian/Caretaker Name _____

Pregnant, Breastfeeding and Nonbreastfeeding PostPartum Women

1. Qualifying medical condition(s):

2. Name of WIC exempt formula/ medical food prescription:

Prescribed amount per day: _____ Physical Form: Powder Concentrate Ready to Use

Special instructions for preparation and use: _____

3. WIC allowed foods (please check appropriate box(es); note post-partum non breastfeeding women are not eligible to receive whole wheat bread):

- | | | |
|--|--|---|
| <input type="checkbox"/> <i>All foods</i> | <input type="checkbox"/> Breakfast cereal | <input type="checkbox"/> Whole wheat bread or |
| <input type="checkbox"/> <i>No foods</i> | <input type="checkbox"/> Fresh fruits and vegetables | other whole grains |
| <input type="checkbox"/> <i>All EXCEPT (check all that apply):</i> | <input type="checkbox"/> Reduced fat milk | <input type="checkbox"/> 100% juice |
| <input type="checkbox"/> Fish (fully breastfeeding women only) | <input type="checkbox"/> Eggs | <input type="checkbox"/> Beans and/or peanut butter |

4. Length of use: 1 month 3 months 6 months 12 months Other _____

Qualifying conditions include, but are not limited to:

- Inborn errors of metabolism and metabolic disorders
- Gastrointestinal disorders
- Malabsorption syndromes
- Immune system disorders
- Severe food allergies that require an elemental formula
- Diseases and medical conditions that impair ingestion, digestion, absorption or the utilization of nutrients that could adversely affect the participant's nutrition status

Non-qualifying conditions:

- Food intolerance
- Management of body weight without underlying medical condition
- Patient preference

SIGNATURE (Health Care Provider) :

Date:

Printed Name (Health Care Provider):

Medical Office/ Clinic:

Telephone:

Address:

WIC Staff Use Only: