

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: <input type="checkbox"/> Enfamil Infant <input type="checkbox"/> Enfamil Gentlease <input type="checkbox"/> Enfamil ProSobee <input type="checkbox"/> Enfamil AR <input type="checkbox"/> Enfamil Reguline | <input type="checkbox"/> Enfamil NeuroPro Enfacare (pwd) <input type="checkbox"/> Similac Neosure (pwd) <input type="checkbox"/> ready-to-feed <input type="checkbox"/> Alimentum (pwd) <input type="checkbox"/> ready-to-feed <input type="checkbox"/> Nutramigen w/Probiotic LGG | <input type="checkbox"/> Pregestimil <input type="checkbox"/> Similac PM 60/40 <input type="checkbox"/> Neocate Infant DHA/ARA <input type="checkbox"/> Neocate Syneo Infant <input type="checkbox"/> EleCare DHA/ARA <input type="checkbox"/> PurAmino DHA/ARA |

2. FOOD PRESCRIPTION

| |
|-----------------------------------------------------------------------------------------------------------------------------|
| Infant (0-11 months of age) – Choose One |
| <input type="checkbox"/> Formula ONLY (no foods during duration of this prescription) |
| <input type="checkbox"/> 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 **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).

| | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cleft Lip / Palate <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Developmental Delay <input type="checkbox"/> Eosinophilic GI | <input type="checkbox"/> Gastroesophageal Reflux <input type="checkbox"/> Intestinal Malabsorption <input type="checkbox"/> Prematurity (up to 2 years) <input type="checkbox"/> Tube Fed NPO <input type="checkbox"/> Tube Fed | <input type="checkbox"/> Confirmed Allergy (specify): _____ | <input type="checkbox"/> 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: _____

This institution is an equal opportunity provider.

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)

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

| | | | |
|---------------------------------------------------|------------------------------------------------------|--------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Gastroesophageal Reflux | <input type="checkbox"/> Confirmed Allergy | <input type="checkbox"/> Other Medical Diagnosis |
| <input type="checkbox"/> Cleft Lip / Palate | <input type="checkbox"/> Intestinal Malabsorption | (specify): _____ | (specify): _____ |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Prematurity (up to 2 years) | | |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Tube Fed NPO | | |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Tube Fed | | |
| <input type="checkbox"/> 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.