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)	

1. PRESCRIBED FORMULA – Choose One

Infant (0-11 months of age)

6 months or older no foods:
- ☐ Enfamil Infant
- ☐ Enfamil Gentlease
- ☐ Enfamil ProSobee
- ☐ Enfamil AR
- ☐ Enfamil Reguline

- ☐ 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

- ☐ Similac PM 60/40
- ☐ Neocate Infant DHA/ARA
- ☐ Neocate Syneo Infant
- ☐ EleCare DHA/ARA
- ☐ PurAmino DHA/ARA

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), 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).

☐ Cerebral Palsy ☐ Cleft Lip / Palate ☐ Congenital Heart Disease ☐ Cystic Fibrosis ☐ Developmental Delay ☐ Eosinophilic GI	☐ Gastroesophageal Reflux ☐ Intestinal Malabsorption ☐ Prematurity (up to 2 years) ☐ Tube Fed NPO ☐ Tube Fed	☐ Confirmed Allergy (specify):	☐ 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 (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)	

1. PRESCRIBED FORMULA – Choose One

Children (1 to 4 years)

- ☐ Enfamil Infant
- ☐ Enfamil Gentlease
- ☐ Enfamil ProSobee
- ☐ Enfamil AR
- ☐ Enfamil Reguline
- ☐ Alimentum (pwd)
  - ☐ ready-to-feed*
- ☐ Nutramigen w/Probiotic LGG
  - ☐ ready-to-feed*
- EleCare Jr
  - ☐ unflavored (pwd)
  - ☐ flavored (pwd)
- ☐ PurAmino DHA/ARA
- ☐ Neocate Splash
- ☐ Neocate Junior
- Nutren Junior
  - ☐ without fiber
  - ☐ with fiber
- PediaSure
  - ☐ without fiber
  - ☐ with fiber
- PediaSure 1.5 Cal
  - ☐ without fiber
  - ☐ with fiber
- ☐ PediaSure Peptide 1.0 Cal
- Peptamen Junior
  - ☐ 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 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).

☐ Cerebral Palsy ☐ Cleft Lip / Palate ☐ Congenital Heart Disease ☐ Cystic Fibrosis ☐ Developmental Delay ☐ Eosinophilic GI	☐ Gastroesophageal Reflux ☐ Intestinal Malabsorption ☐ Prematurity (up to 2 years) ☐ Tube Fed NPO ☐ Tube Fed	☐ Confirmed Allergy (specify):	☐ Other Medical Diagnosis (specify):

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

Date:

Phone:

Fax:

Printed Name:

Medical Office:

Address:

This institution is an equal opportunity provider.