

WIC Program Medical Documentation Child (12 Months of Age and Older) or Woman

Complete sections A and D for all prescriptions.

- ▶ To prescribe a **formula or product** for a child (12 months of age or older) or a woman, also complete **section B**.
- ▶ To prescribe **whole milk** for a child (24 months of age or older) or a woman, also complete **section C**.

Prescription is subject to WIC approval and provision based on program policy and procedures.

A. PARTICIPANT INFORMATION

Participant's name:	DOB:
Medical condition(s) indicating need for prescribed product:	
Duration of prescription (limited to 12 months):	

B. FORMULA/PRODUCT AND WIC SUPPLEMENTAL FOODS

Formula/product prescribed:															
Amount prescribed per day:															
Special instructions for preparation or dilution:															
Supplemental foods: <input type="checkbox"/> No Supplemental foods are allowed for this participant. Offering these foods is contraindicated at this time. — or — Identify <u>any</u> WIC supplemental foods <u>not</u> allowed for this participant, otherwise some or all of the following foods may be provided depending on the participant category. <table><tr><td><input type="checkbox"/> No Milk</td><td><input type="checkbox"/> No Breakfast Cereal</td><td><input type="checkbox"/> No Juice</td></tr><tr><td><input type="checkbox"/> No Whole-wheat Bread or Other Whole Grains</td><td><input type="checkbox"/> No Fruits and Vegetables</td><td><input type="checkbox"/> No Peanut Butter</td></tr><tr><td><input type="checkbox"/> No Cheese</td><td><input type="checkbox"/> No Tofu</td><td><input type="checkbox"/> No Legumes</td></tr><tr><td><input type="checkbox"/> No Canned Fish (fully-breastfeeding women only)</td><td><input type="checkbox"/> No Yogurt</td><td><input type="checkbox"/> No Eggs</td></tr><tr><td><input type="checkbox"/> No Soy-Based Beverages</td><td></td><td></td></tr></table>	<input type="checkbox"/> No Milk	<input type="checkbox"/> No Breakfast Cereal	<input type="checkbox"/> No Juice	<input type="checkbox"/> No Whole-wheat Bread or Other Whole Grains	<input type="checkbox"/> No Fruits and Vegetables	<input type="checkbox"/> No Peanut Butter	<input type="checkbox"/> No Cheese	<input type="checkbox"/> No Tofu	<input type="checkbox"/> No Legumes	<input type="checkbox"/> No Canned Fish (fully-breastfeeding women only)	<input type="checkbox"/> No Yogurt	<input type="checkbox"/> No Eggs	<input type="checkbox"/> No Soy-Based Beverages		
<input type="checkbox"/> No Milk	<input type="checkbox"/> No Breakfast Cereal	<input type="checkbox"/> No Juice													
<input type="checkbox"/> No Whole-wheat Bread or Other Whole Grains	<input type="checkbox"/> No Fruits and Vegetables	<input type="checkbox"/> No Peanut Butter													
<input type="checkbox"/> No Cheese	<input type="checkbox"/> No Tofu	<input type="checkbox"/> No Legumes													
<input type="checkbox"/> No Canned Fish (fully-breastfeeding women only)	<input type="checkbox"/> No Yogurt	<input type="checkbox"/> No Eggs													
<input type="checkbox"/> No Soy-Based Beverages															

C. WHOLE MILK — CHILD (24 MONTHS OF AGE OR OLDER) OR WOMAN

<input type="checkbox"/> Whole milk prescribed. Otherwise, these individuals receive skim/1%.

D. HEALTH CARE PROVIDER INFORMATION

Signature of health care provider:		
Provider's name (please print):		
Medical office/clinic (include address):		
Phone #:	Fax #:	Date:

Contact your local WIC program with any questions about current policy or for more information.