

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:

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

*Ready-to-feed must meet Federal Requirements for issuance

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).

<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 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)	Date: _____
Signature: _____	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)

- | | | | |
|--|---|--|--|
| <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"/> ready-to-feed* | <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 | |

*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).

<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 (Physician, Physician Assistant or Advanced Practice Nurse Practitioner) _____ Date: _____
Signature: _____ Phone: _____
Fax: _____

Printed Name: _____ Medical Office: _____

Address: _____

This institution is an equal opportunity provider.