Florida HEALTH

Florida WIC Program

Medical Documentation for Formula and Food

Please have the client/caregiver return this completed form to the WIC office or Fax it to the WIC office.

The Florida WIC Program supports the American Academy of Pediatrics' Statement on Breastfeeding and the Use of Human Milk. Final determination of the approval and provision of formula and food will be based on Florida WIC Program policies and procedures. **This form must be completed with a qualifying medical condition for infants to receive a formula other than a WIC contract formula OR for children 1 year and older or women to receive either a contract formula, other type of formula, or nutritional product.** Please read the back of this form for more information about the WIC contract formulas, Florida WIC policies, and list of qualifying medical conditions. **Health care provider must complete shaded areas. If formula requested box is checked, then "Formula Requested" does not need to be entered. Review instructions in Section B and make selections, if applicable.**

SECTION A: FORMULA(S) REQUESTED

Client's Name: _____ **Date of Birth:** _____

Formula Requested: _____ **Amount per day:*** _____ ounces

Formula Requested: _____ **Amount per day:** _____ ounces

OR, for infant less than 12 months of age in need of a hypoallergenic, elemental, or premature powder formula, check one of the boxes below. Formula will be assigned based on availability.

❑ Alimentum, Extensive HA, Nutramigen, or Pepticate

❑ Alfamino, Elecare, Neocate, Neocate Syneo, or Puramino ❑ Enfamil EnfaCare or Similac NeoSure

***Amount per day** can be left blank when requesting one formula for an infant less than 12 months of age—the infant will receive the maximum WIC monthly amount unless a lesser amount is requested. Amount per day must be entered for all other clients and for clients with special mixing instructions or if mixing instructions are not specified by the manufacturer. Enter mixing instructions in the **Special Instructions** section below.

Length of use in months: ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 ❑11 ❑12 Cannot exceed 12 months.

Qualifying medical condition(s): _____

"Failure to Thrive" medical condition must be accompanied by current height/length and weight.

Height/Length: _____inches **Weight:** _____ lb. _____oz. **Date of measurement:** _____

Special instructions: _____

SECTION B: WIC SUPPLEMENTAL FOODS

Make selections below. If nothing is checked, all standard WIC supplemental foods will be provided unless contraindicated due to food allergy/intolerance or when the client does not want the food item. When cow milk protein intolerance or allergy is documented, yogurt, cheese, and cow milk will **not** be provided even if requested.

Infant age 6 through 11 months

Baby cereal and baby fruits and vegetables are standard WIC foods at this age. WIC does not provide baby foods to infants less than 6 months of age.

Check one box below for an infant who cannot be provided all standard WIC baby foods due to a medical condition:

- ❑ formula only - no baby foods
- ❑ formula and baby cereal only
- ❑ formula and baby fruits and vegetables only

Woman or Child 1 year and older

❑ **Provide formula/nutritional product only - do not provide WIC supplemental foods.**

Child that is prescribed formula/nutritional product requires: (Check all that apply.)

❑ baby cereal **instead of** regular breakfast cereal

❑ baby fruits and vegetables **instead of** regular fruits and vegetables

What type of milk do you want WIC to provide? (See side 2 for WIC policy regarding milk.)

❑ whole milk ❑ 1% lowfat or fat free milk ❑ 2% milk

❑ lactose-free whole milk ❑ lactose-free 1% or fat free milk ❑ lactose-free 2% milk

❑ no milk ❑ soy milk

Select foods to omit: ❑ no yogurt ❑ no cheese ❑ no juice ❑ no beans

❑ no breakfast cereal ❑ no eggs ❑ no fruits and vegetables ❑ no tofu

❑ no whole grain foods such as bread, pasta, tortillas, brown rice, oatmeal, or bulgur

❑ no peanut butter (only provided for a woman or child 2 years and older)

❑ no fish

SECTION C: HEALTH CARE PROVIDER INFORMATION

Physician, APRN, or PA include credentials below

Name (print): _____

Signature: _____

Date: _____

Must print or stamp below:

Address: choose

CCO

FMO

ESO

Phone Number: 239 768 2111

Fax Number: 239 768 2113

ISLAND COAST PEDIATRICS

Once approved by WIC staff, this request is valid for the number of months specified starting from the health care provider signature date. The need for approved formula will be re-evaluated by WIC staff on a periodic basis.

RESET

PRINT