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:

- ☐ 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

- ☐ Pregestimil
- ☐ 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 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)

- ☐ Enfamil Infant
- ☐ Enfamil Gentlease
- ☐ Enfamil ProSobee
- ☐ Enfamil AR
- ☐ Enfamil Reguline
- ☐ Alimentum (pwd)
  - ☐ ready-to-feed
- ☐ Nutramigen w/Probiotic LGG
- ☐ Pregestimil

EleCare Jr
- ☐ unflavored (pwd)
- ☐ flavored (pwd)

- ☐ PurAmino DHA/ARA
- ☐ Neocate Splash
- ☐ Neocate Junior
- ☐ Neocate Junior w/Prebiotics

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

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 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.