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 NeuroPro Enfacare (pwd)	☐ Pregestimil
☐ Enfamil Gentlease	☐ Similac Neosure (pwd) ☐ ready-to-feed	☐ Similac PM 60/40
☐ Enfamil ProSobee	☐ Alimentum (pwd) ☐ ready-to-feed	☐ Neocate Infant DHA/ARA
☐ Enfamil AR	☐ Nutramigen w/Enflora LGG	☐ Neocate Syneo Infant
☐ Enfamil Reguline		☐ 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	☐ Gastroesophageal Reflux	☐ Confirmed Allergy (specify):	☐ Other Medical Diagnosis (specify):
☐ Cleft Lip / Palate	☐ Intestinal Malabsorption		
☐ Congenital Heart Disease	☐ Prematurity (up to 2 years)		
☐ Cystic Fibrosis	☐ Tube Fed NPO		
☐ Developmental Delay	☐ Tube Fed		
☐ 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 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 Enflora 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
  - ☐ with Prebio

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.

March 2021