

# WIC Medical Documentation Form

North Dakota Department of Health - Division of Nutrition and Physical Activity- WIC Program

To authorize a special WIC-approved formula or WIC-eligible nutritional (medical food), complete this form, then fax to \_\_\_\_\_ or have the participant return it to their local WIC office.

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

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## COMPLETE IF PRESCRIBING A SPECIAL FORMULA OR WIC-ELIGIBLE NUTRITIONAL (MEDICAL FOOD)

**Not Allowed: Similac Advance, Soy Isomil, Sensitive, Spit-Up; Gerber Good Start Gentle, Soy, Soothe; store brand formulas**

WIC Special Formula or WIC-eligible Nutritional (Medical Food) Requested: \_\_\_\_\_

**Medical Diagnosis: (Not Acceptable Diagnoses - formula intolerance, spitting up, or colic)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Lactose intolerance                 | <input type="checkbox"/> <input type="checkbox"/> Gastroesophageal reflux disease (GERD) | <input type="checkbox"/> <input type="checkbox"/> Prematurity/low birth weight |
| <input type="checkbox"/> <input type="checkbox"/> Inadequate growth/Failure to thrive | <input type="checkbox"/> <input type="checkbox"/> Allergy to milk products               | <input type="checkbox"/> <input type="checkbox"/> Soy or corn allergy          |
| <input type="checkbox"/> <input type="checkbox"/> Malabsorption syndromes             | <input type="checkbox"/> <input type="checkbox"/> Gastrointestinal disorders             | <input type="checkbox"/> <input type="checkbox"/> Nutrient deficiency          |
| <input type="checkbox"/> <input type="checkbox"/> Cerebral palsy                      | <input type="checkbox"/> <input type="checkbox"/> Developmental sensory/motor delays     | <input type="checkbox"/> <input type="checkbox"/> Heart/circulatory            |
| <input type="checkbox"/> <input type="checkbox"/> Other medical diagnosis: _____      |  |  |

Time Needed: \_\_\_\_\_ months OR  Until 1 year of age      Prescribed Amount:  Full Amount Allowed OR \_\_\_\_\_ oz/day

Instructions for Preparation: \_\_\_\_\_ Caloric Density: \_\_\_\_\_ kcal/oz (22, 24, etc.)

**WIC Foods: (Check ONE box only.)**

Refer to the WIC dietician or nutritionist to determine the WIC foods provided.

OR

Issue full amount of age-appropriate WIC foods;

OR

Issue no WIC foods; provide formula only;

OR

Issue a food package without the WIC foods checked below.

**Infants (6 through 11 months)**     Infant Cereal     Baby Food Fruits/Vegetables     Baby Food Meats

Fresh Fruits/Vegetables

**Children (1 through 4 years old) and Women**     Cheese     Cereal     Juice     Eggs     Beans/Peas

Whole Wheat Bread/Brown Rice/Tortillas     Peanut Butter     Fruits/Vegetables     Tuna/Salmon     Milk

Soy Milk

**Baby Food Fruits and Vegetables:**  Issue baby food fruits and vegetables instead of fresh fruits and vegetables for children (1 through 4 years old). **Only children receiving a formula/WIC-eligible nutritional (medical food) with a qualifying medical diagnosis can get baby food fruits and vegetables.**

**Whole Milk:**  Issue whole milk for a child over 2 or a woman. **Only participants receiving a formula/WIC-eligible nutritional (medical food) with a qualifying medical diagnosis can get whole milk.** (WIC regulations specify 1% or fat free skim milk for women and children 2 years of age and older.)

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## COMPLETE FOR ALL

Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Health Care Provider's Name: \_\_\_\_\_  MD  DO  NP  PA

Clinic/Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

For more information or help in completing this form: Contact \_\_\_\_\_ at \_\_\_\_\_.