Pennsylvania WIC PROGRAM
Formula Authorization Form

Client's First & Last Name_____ **Birth Date**_____

Parent/Caregiver's First & Last Name_____

1. Formula/Fortifier Requested _____

Amount requested: ___ oz/day (if formula) ___ pkg/day (if fortifier) ___ Tbsp/day (if modular formula)

Intended length of use: □ 1 month □ 3 months □ 6 months □ through this date_____ (max 6 months)
(Monthly renewal required for premature formulas or breast milk fortifiers. WIC recommends re-challenging with primary infant formula after solids have been introduced, generally at 6 months of age.)

Via tube feeding? □ Yes □ No

Special instructions for preparation and use (if necessary): _____

_____

2. Qualifying Medical Condition(s): _____ ICD-9 Code: _____
Justifies the prescription of above formula or fortifier.

3. Are there any WIC food restrictions? □ Yes □ No
*If yes, please check the foods below that your client should **not** receive from WIC as well as length of restriction.*
Infants (6-11 months): □ infant cereal □ infant vegetable or fruit □ infant meat

Children & Women: □ juice □ breakfast cereal □ whole wheat bread or other whole grains
□ eggs □ vegetables & fruits □ fish (tuna/salmon/sardine/mackerel)
□ legumes □ peanut butter (available after age 2 only)
□ Tofu □ Soy beverage □ 1% or skim milk
□ whole milk for Children 1-2 years of age

Length of restriction: □ 1 month □ 3 months □ 6 months □ Other: _____

Reasons/Instructions/Comments: _____

_____

4. Authorization for whole or 2% milk (ONLY for women or children >2 years AND on exempt formula or WIC-eligible nutritional): □ Whole Milk □ 2% Milk

Signature: _____ **Date:** _____
Physician, Certified Registered Nurse Practitioner, Physician Assistant

Printed Name: _____
Medical Office/ Clinic: _____ **Telephone:** _____
Address: _____ **Fax:** _____