WEST VIRGINIA WIC PROGRAM

Prescription Formula Form for Prescribed Formulas and Foods

Section A: Complete for Exempt, 19 Calorie Formula or Nutritional
Section B: Complete for all patients, if applicable
Section C: Complete for all patients

Please fax completed form to WIC Clinic or have Parent/Guardian return to WIC Clinic

PATIENT INFORMATION

Patient's Full Name: **DOB:**

Parent/Guardian Name:

A. EXEMPT FORMULA OR 19 CALORIE FORMULA *(Similac Sensitive for Fussiness & Gas, Similac for Spit up, Similac Total Comfort)* **OR WIC-ELIGIBLE NUTRITIONAL**

Medical Reason/Diagnosis:

Formula Requested: **Prescribed Amount:** **oz./day**

Prescribed Form: ☐ Powder ☐ Concentrate ☐ Ready to Feed | ☐ Formula Change or ☐ Renewal

Time Needed: ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ 4 Months ☐ 5 Months ☐ 6 Months

B. SUPPLEMENTAL FOODS

In addition to the infant formula/nutritionals, supplemental foods appropriate to the WIC participant category will be provided. Please mark the appropriate boxes below to indicate any foods that would be *contraindicated* with the patient's diagnosis.

☐ **No Supplemental foods at this time:** Omit all supplemental foods and provide formula or nutritionals ONLY.

WIC Category	WIC Supplemental Foods Available	Do Not Give	Restrictions/Special Instructions
Infants 6 – 11 months	Infant Cereal		
	Infant Fruits/Vegetables		
Children and Women ***Please note:*** *Fish is only for fully breastfeeding women, women who are pregnant with multiples and pregnant women who are breastfeeding.*	Milk		
	Cheese		
	Eggs		
	Juice		
	Breakfast Cereals		
	Legumes and/or Peanut Butter		
	Fruits and Vegetables		
	Whole Grains		
	*Fish		

C. HEALTH CARE PROVIDER INFORMATION

Health Care Provider's Name (Please Print): ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA**

Medical Office/Clinic:

Phone Number: **Fax Number:**

Signature of Health Care Provider: **Date:**

WIC USE ONLY

Approved by: **Date:**