REQUIRED MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS - CHILDREN (1 UP TO 5 YEARS)

State Form 55323 (R4 / 5-19)
INDIANA STATE DEPARTMENT OF HEALTH
INDIANA WOMEN, INFANTS, & CHILDREN PROGRAM (WIC)

Patient's Name: _____ **Birthdate** *(mm/dd/yyyy)*: _____

Attention Clinic Staff: **Scan this form into the Client Section of the INWIC Communication screen. A Release of Information Form must be signed and scanned before faxing to the healthcare provider. – Thank you**

PLEASE COMPLETE EACH SECTION FOR YOUR CHILD PATIENT.

1. Qualifying conditions include, but are not limited to: *(Check all that apply.)*

- ☐ Premature birth
- ☐ Low birth weight
- ☐ Gastrointestinal disorders
- ☐ Failure to thrive
- ☐ Immune system disorder
- ☐ Malabsorption syndromes
- ☐ Severe food allergies that require an elemental formula
- ☐ Inborn errors of metabolism and metabolic disorders
- ☐ Diseases and medical conditions that impair ingestion, digestion, absorption or the utilization of nutrients that could adversely affect the participant's nutrition status

2. Name of WIC standard or exempt infant formula / WIC-eligible nutritionals prescription:

_____

Prescribed amount per day: _____

Physical Form: ☐ Powder ☐ Concentrate ☐ Ready to Use

Special instructions for preparation and use: _____

3. Allowed WIC foods *(Please check appropriate boxes.)*

☐ ***No Foods***	☐ ***All Foods EXCEPT (Check all that apply.):***
☐ ***All foods***	☐ Breakfast cereal ☐ Milk ☐ Soy Milk
(Children 12-24 months receive Whole Milk only.)	☐ Fresh/frozen/canned fruit and vegetables ☐ 100% juice
(Children >24 months receive 1% or Skim Milk only.)	☐ Eggs ☐ Whole wheat bread or other whole grains
(Soy Milk and Tofu can be made available unless indicated as an exception in the "All Foods Except" box.)	☐ Cheese ☐ Beans or peanut butter
	☐ Yogurt ☐ Tofu

The following choices may be provided for the specified age group for patients with a qualifying condition. Please check all that apply. A length of use is still required when ordering these items. (Formula or WIC-eligible nutritionals are not required for the patient to receive these items.)

All ages	☐ Infant cereal (in place of breakfast cereal)			☐ Pureed fruits and vegetables (in place of fresh/frozen/canned fruit and vegetables)		
Child 12-24 month	☐ 2% Milk	☐ 1% Milk	☐ Skim Milk	***Child ≥ 24 month***	☐ Whole Milk	☐ 2% Milk

4. Length of use for this prescription: ☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months (maximum approval)

Other: _____

SIGNATURE *(Health Care Provider)*: _____ Date *(mm/dd/yyyy)*: _____

Printed Name *(Health Care Provider)*: _____

Medical Office / Clinic: _____ Telephone: _____

Address *(number and street, city, state, and ZIP code)*: _____

WIC Staff Use Only: Non-qualifying conditions:

- Food intolerance
- Patient preference
- Management of body weight with no underlying medical condition

This institution is an equal opportunity provider.