

WIC Program Medical Documentation Infant (Birth to 12 Months of Age)

The WIC Program promotes breastfeeding for infants the first year of life and beyond and actively supports the American Academy of Pediatrics' Statement on Breastfeeding and the Use of Human Milk.

A written prescription is required for an infant who uses a formula/product other than a North Carolina WIC contract milk- or soy-based infant formula. Prescription is subject to WIC approval and provision based on program policy and procedures.

Please complete all sections (A-D) for all prescriptions.

A. PARTICIPANT INFORMATION

Participant's name:	DOB:
Medical condition(s) indicating need for prescribed product:	

B. FORMULA/PRODUCT

Formula/product prescribed:
EnfaCare
Amount prescribed per day:
Special instructions for preparation or dilution:
Duration of prescription (limited to 12 months of age):

C. SUPPLEMENTAL FOODS

Beginning at six months of age through the 11th month of age, WIC supplemental foods are available in addition to the prescribed formula. Please indicate which foods this infant should <u>not</u> receive for the duration of this prescription.	
<input type="checkbox"/> No Infant Cereal	<input type="checkbox"/> No Infant Fruits or Vegetables

D. HEALTH CARE PROVIDER INFORMATION

Signature of health care provider:		
Provider's name (please print):		
Medical office/clinic (include address):		
Phone #:	Fax #:	Date:

Contact your local WIC program for information on formulas allowed.

WIC Program Medical Documentation Child (12 Months of Age and Older) or Woman

Complete sections A and D for all prescriptions.

- ▶ To prescribe a **formula or product** for a child (12 months of age or older) or a woman, also complete **section B**.
- ▶ To prescribe **whole milk** for a child (24 months of age or older) or a woman, also complete **section C**.

Prescription is subject to WIC approval and provision based on program policy and procedures.

A. PARTICIPANT INFORMATION

Participant's name:	DOB:
Medical condition(s) indicating need for prescribed product:	
Duration of prescription (limited to 12 months):	

B. FORMULA/PRODUCT AND WIC SUPPLEMENTAL FOODS

Formula/product prescribed: PurAmino												
Amount prescribed per day:												
Special instructions for preparation or dilution:												
Supplemental foods: <input type="checkbox"/> <u>No</u> Supplemental foods are allowed for this participant. Offering these foods is contraindicated at this time. — or — Identify <u>any</u> WIC supplemental foods <u>not</u> allowed for this participant, otherwise some or all of the following foods may be provided depending on the participant category. <table border="0"><tr><td><input type="checkbox"/> No Milk</td><td><input type="checkbox"/> No Juice</td><td><input type="checkbox"/> No Breakfast Cereal</td></tr><tr><td><input type="checkbox"/> No Whole-wheat Bread or Other Whole Grains</td><td><input type="checkbox"/> No Eggs</td><td><input type="checkbox"/> No Fruits and Vegetables</td></tr><tr><td><input type="checkbox"/> No Cheese</td><td><input type="checkbox"/> No Peanut Butter</td><td><input type="checkbox"/> No Legumes</td></tr><tr><td><input type="checkbox"/> No Canned Fish (fully-breastfeeding women only)</td><td><input type="checkbox"/> No Tofu</td><td><input type="checkbox"/> No Soy-based Beverages</td></tr></table>	<input type="checkbox"/> No Milk	<input type="checkbox"/> No Juice	<input type="checkbox"/> No Breakfast Cereal	<input type="checkbox"/> No Whole-wheat Bread or Other Whole Grains	<input type="checkbox"/> No Eggs	<input type="checkbox"/> No Fruits and Vegetables	<input type="checkbox"/> No Cheese	<input type="checkbox"/> No Peanut Butter	<input type="checkbox"/> No Legumes	<input type="checkbox"/> No Canned Fish (fully-breastfeeding women only)	<input type="checkbox"/> No Tofu	<input type="checkbox"/> No Soy-based Beverages
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C. WHOLE MILK — CHILD (24 MONTHS OF AGE OR OLDER) OR WOMAN

<input type="checkbox"/> Whole milk prescribed. Otherwise, these individuals receive skim, 1%, or 2% milk.
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D. HEALTH CARE PROVIDER INFORMATION

Signature of health care provider:		
Provider's name (please print):		
Medical office/clinic (include address):		
Phone #:	Fax #:	Date:

Contact your local WIC program with any questions about current policy or for more information.