

Pennsylvania WIC Program Formula Authorization Form



Client's First & Last Name _____ Birth Date _____

Parent/Caregiver's First & Last Name _____

1. Formula requested: _____

Amount requested: ____ oz/day (if formula) ____ Tbsp/day (if modular formula)

Length of use: 1 month 3 months 6 months through this date _____ (max 6 months)
(Monthly renewal required for pre-discharge premature formulas. WIC encourages re-challenge with primary infant formula after solids have been introduced, generally at 6 months of age, with physician approval.)

Via tube feeding? Yes No

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

2. Qualifying Medical Condition(s): _____ ICD-10 Code: _____

(Justifies the prescription of above formula).

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: tofu soy beverage milk yogurt cheese
 juice breakfast cereal whole wheat bread or other whole grains
 eggs vegetables & fruits fish (tuna/salmon/sardines)
 legumes peanut butter (available after age 2 only)

Length of restriction: 1 month 3 months 6 months other: _____

Reasons/Instructions/Comments: _____

4. WIC authorizes the following types of milk and yogurt:

a. whole fat milk and yogurt for children 12-23 months.

Check box below if other than whole milk is indicated:

milk: 2% 1% skim soy beverage tofu: 1-4 lbs: ____ > 4 lbs: ____ yogurt: low fat/non fat

b. 1% or skim milk or lowfat/nonfat yogurt for women and children age 2 and over.

Check box below if other than 1% or skim milk is indicated:

milk: whole* 2% soy beverage tofu: 1-4 lbs: ____ > 4 lbs: ____ yogurt: whole fat

* Whole milk may be provided for women and children age 2 and over, only if a special formula is prescribed.

Signature: _____ Date: _____

Physician, Certified Registered Nurse Practitioner, Certified Nurse Midwife, Physician Assistant

Printed Name: _____

Medical Office/ Clinic: _____ Telephone: _____

Address: _____ Fax: _____