Medical Prescription Form

Infants not exclusively breastfed are **provided Similac Advance, Similac Sensitive, Similac Gentle Comfort or Similac Soy Isomil**. This form is federally required to request an exempt infant formula/WIC-eligible nutritional for qualifying medical conditions. All requests are subject to WIC approval.

REQUIRED: PATIENT INFORMATION

Patient Name: _____ **Patient DOB:**_____

Medical Data *(optional)*:	Weight:	Length/Height:	Hgb:
Measurement:			
Date Measured:			

REQUIRED: FORMULA ISSUANCE

WIC provides powdered forms of exempt formula, RTF formula only available in limited circumstances.

Formula Requested: _____ **Amount oz/per day:** _____

Duration: ☐ 3 Months ☐ 6 Months ☐ Other *(Requires justification)*:_____

Gastroesophageal Reflux Disease (GERD)	☐	Developmental Disorder	☐
Severe Food Allergy	☐	Metabolic Disorder	☐
Intestinal Malabsorption	☐	Immune System Disorder	☐
Failure to Thrive (FTT)	☐	Inappropriate Growth Pattern	☐
Premature Birth or Low Birth Weight	☐	Cow's Milk Protein Allergy	☐
Other Diagnosis:			
Reasons below listed are not eligible for DC WIC exempt formula issuance:			
Fussiness, spitting up, gas, constipation, lactose intolerance, non-specific formula or food intolerance, participant preference, solely to enhance nutrient intake, managing body weight without a medical condition			

REQUIRED: WIC FOOD REQUESTS

☐ WIC Dietitian/Nutritionist may determine WIC foods and amounts.

☐ **NO solid foods** - ***Only*** issue formula/WIC-eligible nutritional

☐ **Opt in for whole milk or** ☐ **2% milk for *children ≥ 2 years and women.*** *Nonfat or low-fat milk is standard issuance for children ≥2 years and women. Selecting this will replace the non- and low-fat milk with whole milk or 2% milk.*

☐ Issue infant foods *(infant cereal and jarred fruits and vegetables)* to children ≥ 1 years and women

☐ Do NOT issue the following WIC foods: _____

REQUIRED: HEALTH CARE PROVIDER with PRESCRIPTIVE AUTHORITY

Credentials: ☐MD, ☐ DO, ☐ PA, ☐ CRNA, ☐ CNM, ☐ CNP, ☐ CRNP, ☐ NP, ☐ DNP

Provider's Name: _____ Phone Number: _____

Provider's Signature: _____ Date: _____

For WIC Use Only:	
Authorizing CPA Signature:	Name:
Date Received:	Rx Expiration Date:

This institution is an equal opportunity provider.

For additional information visit *www.dcwic.org/wic-providers*