NEW YORK STATE DEPARTMENT OF HEALTH
DIVISION OF NUTRITION

MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS FOR INFANTS, CHILDREN AND WOMEN

Patient's Name _____ Birth Date: (MM/DD/YY) _____

Parent/Caretaker's First and Last Name_____

I authorize _____ (Health Care Provider) to release the information below to the WIC Program, and I authorize the WIC Program to release information about me to this health care provider for the purposes of coordinating my health care. If I need to transfer to another WIC Program, I authorize the release of this information to the transferring WIC Program. All information is considered confidential.

YOUR SIGNATURE: _____

Prescription is subject to WIC approval and provision based on Program policy and procedure.

Qualifying medical condition(s) including ICD-9 code: Justifies the prescription of requested formula/medical food

_____ ICD-9 Code_____

WIC formula/medical food requested: _____

Prescribed amount per day: _____ oz/day Special Instructions/Comments:_____

Length of use: _____ (Prescription renewal required periodically)

The patient will receive the supplemental foods, appropriate to their WIC participant category, listed below in addition to the WIC formula/medical food. Please indicate any supplemental foods or restrictions that would be contraindicated with the patient's medical diagnosis.

WIC Participant Category	WIC Supplemental Foods Available	Do Not Give	Restrictions/Comments
Infants (6-12 months)	Infant Cereal		
	Infant Food Vegetables/Fruits		
Children and Women	Milk		
	Cheese		
	Cereal		
	Juice		
	Eggs		
	Vegetables/Fruits		
	Whole Wheat Bread		
	Beans		
	Peanut Butter		
	Canned Fish *		

* "Fully Breastfeeding Women" is the only WIC participant category eligible to receive canned fish.

	Provider's Name (Please Print):
Signature of Health Care Provider	Title:
	Medical Office/Clinic:
	Street:
	City: Zip:
	Phone #: Fax #:
	Date: / /

This institution is an equal opportunity provider.