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:** _____

PA WIC is funded by the USDA.
This institution is an equal opportunity provider.