



**New Jersey Department of Health
WIC Services**

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

WIC Office	Phone	Fax	E-Mail
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Please complete entire form. Fax or email the completed form to the WIC office or have your patient return the form to the WIC office. Thank You.

PLEASE NOTE: It is the responsibility of the health care provider to provide close medical oversight and instructions to participants issued exempt infant formula, WIC-eligible Nutritionals and/or supplemental foods that require medical documentation. This responsibility cannot be assumed by personnel at the WIC State or local agency.

Updated Medical Documentation is required every three months.

- **No authorization is necessary for Enfamil Infant, Enfamil Gentlease and Prosobee. Documentation for Enfamil AR is requested, but not required.**

Patient Name (First and Last)	Current Height/Length:
Date of Birth	Current Weight:
Parent/Caregiver Name (First and Last)	Date

1. Formula Requested: _____ Alternative Formula(if first formula not available): _____
 Amount Requested: Maximum Allowable OR _____ ounces/day (if formula)
 Physical Form: Powder Concentrate
 Intended Length of Use: 1 Month 2 Months 3 Months 6 Months

2. Qualifying Condition(s) *(Justifies the medical need.)* **(Complete and submit Page 2 with this form.)**

3. Can patient receive supplemental (or other WIC) foods in addition to formula or medical food? Yes No
*(If Yes, please check the foods below that your patient **CAN / IS** eating.)*

Infants (6-11 months only):
 Infant Cereal Infant Vegetable or Fruit

Children and Women:
 Juice Breakfast Cereal Whole Wheat Bread or Other Whole Grains Eggs
 Vegetables and Fruits Milk or Milk Substitutes Legumes Canned Fish* Peanut Butter

Reasons/Instructions/Comments: _____

**Fully breastfeeding women, women partially breastfeeding multiple infants from the same pregnancy, women pregnant with multiple infants, and pregnant women who are mostly breastfeeding an infant are the only WIC participant categories eligible to receive these foods.*

Health Care Provider Name (Print)	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APN <input type="checkbox"/> PA-C
Medical Office/Clinic	Telephone Number
Medical Office/Clinic Address	Fax Number
Health Care Provider Signature	Date

WIC OFFICE USE ONLY:

Reviewed by CPA Name:	<input type="checkbox"/> Approved # of months: _____ <input type="checkbox"/> Disapproved	Date:	If required: MS and/or RD CPA Name:
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QUALIFYING CONDITIONS

(Please check appropriate Qualifying Conditions.)

Participant Category	Non-Qualifying Conditions	Qualifying Conditions
Infants (up to 12 months)	<ul style="list-style-type: none"> • Non-specific formula or food intolerance • Only condition is a diagnosed formula intolerance or food allergy to lactose, sucrose, milk protein or soy protein that does not require an exempt infant formula 	<input type="checkbox"/> Severe food allergies <input type="checkbox"/> Milk and soy allergies <input type="checkbox"/> Metabolic disorders <input type="checkbox"/> Gastrointestinal disorder <input type="checkbox"/> Mal-absorption disorders <input type="checkbox"/> Premature birth <input type="checkbox"/> Failure to thrive/severely underweight <input type="checkbox"/> Low birth weight <input type="checkbox"/> NG/Tube Fed <input type="checkbox"/> Oral/motor feeding problems <input type="checkbox"/> Immune system disorders <input type="checkbox"/> Life threatening disorders
Children (up to five years of age)	<ul style="list-style-type: none"> • Solely for the purpose of enhancing nutrient intake or managing body weight without an underlying condition • Lactose intolerance • Participant preference 	<input type="checkbox"/> Severe food allergies <input type="checkbox"/> Milk and soy allergies <input type="checkbox"/> Metabolic disorders <input type="checkbox"/> Gastrointestinal disorder <input type="checkbox"/> Mal-absorption disorders <input type="checkbox"/> Premature birth <input type="checkbox"/> Failure to thrive/severely underweight <input type="checkbox"/> Low birth weight <input type="checkbox"/> NG/Tube Fed <input type="checkbox"/> Oral/motor feeding problems <input type="checkbox"/> Immune system disorders <input type="checkbox"/> Life threatening disorders
Women	<ul style="list-style-type: none"> • Solely for the purpose of enhancing nutrient intake or managing body weight without an underlying condition • Lactose intolerance • Participant preference 	<input type="checkbox"/> Severe food allergies <input type="checkbox"/> Milk and soy allergies <input type="checkbox"/> Metabolic disorders <input type="checkbox"/> Gastrointestinal disorder <input type="checkbox"/> Mal-absorption disorders <input type="checkbox"/> NG/Tube Fed <input type="checkbox"/> Oral/motor feeding problems <input type="checkbox"/> Immune system disorders <input type="checkbox"/> Life threatening disorders