IOWA WIC PROGRAM
REQUEST FOR SPECIAL FORMULA AND FOOD

Medical documentation is required for the Iowa WIC Program to authorize special formulas and supplemental foods for WIC participants. Approval is subject to USDA and WIC Program policies.

A. PARTICIPANT INFORMATION

Participant Name: _____ Date of Birth (DOB): _____

Parent/Guardian Name: _____ Phone: _____

B. MEDICAL FORMULA

Formula requested: _____ □ Powder □ Concentrate □ Ready to Use

Prescribed ounces per day: _____ Preparation/Feeding Instructions: _____

**If not specified, up to the WIC maximum allowable may be provided. Maximum allowed might not meet participant's full needs.*

Length of Use: □ 1 month □ 2 months □ 3 months □ 4 months □ 5 months □ 6 months

C. QUALIFYING MEDICAL CONDITION (include ICD-10 Code)

□ Premature birth ≤ 37 weeks gestation (P0710)

□ Failure to thrive (specify underlying medical condition)

_____

□ Severe food allergies (Specify) _____

□ Immune system disorder (Specify) _____

*Symptoms such as spitting up, milk/formula intolerance, fussiness, gas or picky eating are **not** considered acceptable medical diagnoses and will not be approved by WIC for issuance of a special formula. WIC **cannot** provide formula to enhance nutrient intake or manage body weight without underlying medical conditions.*

□ Metabolic disorder/inborn errors of metabolism (Specify) _____

□ Gastrointestinal disorder/malabsorption syndromes (Specify) _____

□ Medical condition that impairs nutrition status (Specify) _____

D. SUPPLEMENTAL FOODS

□ I authorize the WIC RD/Nutritionist to determine supplemental foods and amounts based on medical needs.

□ I do NOT authorize WIC RD/Nutritionists to make decisions about supplemental foods. Select any of the following that apply below:

□ **Formula only**- No foods and increased amount of formula past 6 months of age due to inability/delay consuming solid foods.

□ **Infant foods**- In addition to formula, provide infant foods due to medical condition and inability to consume table foods.

□ **Omit**- The foods indicated here need to be **omitted** from the participant's WIC food package:

□ Milk □ Juice □ Peanut Butter □ Wheat bread □ Oatmeal □ Fruits/Vegetables □ Infant Fruits/Vegetables

□ Eggs □ Cereal □ Beans □ Brown rice □ Tortillas □ Infant cereal

E. HEALTH CARE PROVIDER INFORMATION

Provider's signature (MD, DO, PA, ARNP): _____ Date: _____

Provider's name *(please print)*: _____ Medical Office: _____

Phone: _____ Fax: _____

F. RELEASE OF INFORMATION

I give permission to the WIC Program to release confidential information from my WIC record. I also give permission to the person or agency named above to share requested information. I understand the WIC Program will use this information to provide nutrition services to my family.

Doy el permiso al programa de WIC a la información confidencial del lanzamiento de mi expediente de WIC. También doy el permiso a la persona o a la agencia nombrada arriba compartir la información solicitada. Entiendo que el programa de WIC utilizará esta información para proporcionar servicios de la nutrición a mi familia.

Participant/Parent/Caregiver Signature: _____ Date: _____

G. WIC USE ONLY

WIC Clinic: _____ WIC Phone: _____ WIC Fax: _____

FID #: _____ Comments: _____