WIC SPECIAL FORMULA/FOOD REQUEST

Michigan Department of Health and Human Services

Please Complete ALL Sections (Section 4 is optional)

Client Name	Date of Birth	Parent/Guardian Name

Please specify the underlying qualifying condition below. Conditions such as rash, non-specific intolerance, underweight, fussiness, colic, spitting-up, vomiting, gas and constipation will **NOT** be considered indications for a special formula.

1. QUALIFYING MEDICAL CONDITION(S):

☐ Preterm birth < 37 weeks gestation ☐ Low birth weight (≤ 5 lbs 8 oz) ☐ Failure to thrive

☐ Severe food allergies (specify) _____

☐ Immune system disorder (specify) _____

☐ Metabolic disorder/inborn errors of metabolism (specify) _____

☐ Medical condition that impairs nutrition status (specify) _____

☐ Gastrointestinal disorder/malabsorption syndromes (specify) _____

2. FORMULA: _____

Select Amount Requested: _____ Ounces/day or ☐ Maximum Allowable*

*WIC's Maximum allowable may not meet patient's full need.

Michigan Authorized Formula list is available at: www.michigan.gov/wic.

3. SUPPLEMENTAL FOODS:

☐ **All** (issue all allowed **age appropriate** WIC Foods starting at six months)

☐ **For women/children ≥ 12 months old:** issue infant cereal & infant fruits/vegetables instead of cereal, fruits/vegetables

☐ **Restriction (check foods to be OMITTED):**

Infant (6-12 months)	**Child (1-5 years) and Woman**	
☐ All (issue formula only)	☐ All (issue formula only)	☐ Peanut Butter
☐ Infant cereal	☐ Milk	☐ Breakfast cereal
☐ Infant fruits/vegetables	☐ Yogurt	☐ Bread, rice, tortilla, oatmeal, pasta
	☐ Cheese	☐ Fruits/vegetables
	☐ Eggs	☐ 100% fruit/vegetable juice
	☐ Legumes	☐ Canned fish (women only)

Instructions/Comments: _____

4. MILK SUBSTITUTIONS (optional): Medical Reason: _____

☐ **Whole Milk** (Honored only if medically indicated formula prescribed)

☐ **2% Milk** (In place of ≤ 1% milk, woman/child ≥ 2 years; or whole milk, child 12-23 months)

☐ **Soy Beverage:** ☐ Milk allergy ☐ Lactose intolerance ☐ Cultural /Vegan diet

5. DURATION: ☐ 1 Mo ☐ 2 Mos ☐ 3 Mos ☐ 4 Mos ☐ 5 Mos ☐ 6 Mos (maximum)

6. Medical Provider Name		**WIC Clinic Use Only**	
Address		Approved Through (optional)	
Phone Number	Fax	Name	Phone Number
Signature	Date	Fax	Date

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