North Carolina Department of Health and Human Services
Division of Public Health/Women's and Children's Health Section/Nutrition Services Branch

WIC Program Medical Documentation
Infant (Birth to 12 Months of Age)

The WIC Program promotes breastfeeding for infants the first year of life and beyond and actively supports the American Academy of Pediatrics' Statement on Breastfeeding and the Use of Human Milk.

A written prescription is required for an infant who uses a formula/product other than a North Carolina WIC contract milk- or soy-based infant formula. Prescription is subject to WIC approval and provision based on program policy and procedures.

Please complete all sections (A-D) for <u>all</u> prescriptions.

A. PARTICIPANT INFORMATION

Participant's name:	**DOB:**
Medical condition(s) indicating need for prescribed product:	

B. FORMULA/PRODUCT

Formula/product prescribed:
Amount prescribed per day:
Special instructions for preparation or dilution:
Duration of prescription (limited to 12 months of age):

C. SUPPLEMENTAL FOODS

Beginning at six months of age through the 11th month of age, WIC supplemental foods are available in addition to the prescribed formula. Please indicate which foods this infant should <u>not</u> receive for the duration of this prescription.

❑ No Infant Cereal ❑ No Infant Fruits or Vegetables

D. HEALTH CARE PROVIDER INFORMATION

Signature of health care provider:		
Provider's name (please print)**:**		
Medical office/clinic (include address)**:**		
Phone #:	**Fax #:**	**Date:**

Contact your local WIC program for information on formulas allowed.

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WIC Program Medical Documentation
Child (12 Months of Age and Older) or Woman

Complete sections A and D for all prescriptions.
► To prescribe a **formula or product** for a child (12 months of age or older) or a woman, also complete **section B.**
► To prescribe **whole milk** for a child (24 months of age or older) or a woman, also complete **section C.**

Prescription is subject to WIC approval and provision based on program policy and procedures.

A. PARTICIPANT INFORMATION

Participant's name:	**DOB:**
Medical condition(s) indicating need for prescribed product:	
Duration of prescription (limited to 12 months):	

B. FORMULA/PRODUCT AND WIC SUPPLEMENTAL FOODS

Formula/product prescribed:

Amount prescribed per day:

Special instructions for preparation or dilution:

Supplemental foods:

❑ No Supplemental foods are allowed for this participant. Offering these foods is contraindicated at this time.

— or —

Identify any WIC supplemental foods not allowed for this participant, otherwise some or all of the following foods may be provided depending on the participant category.

❑ No Milk	❑ No Breakfast Cereal	❑ No Juice
❑ No Whole-wheat Bread or Other Whole Grains	❑ No Fruits and Vegetables	❑ No Peanut Butter
❑ No Cheese	❑ No Tofu	❑ No Legumes
❑ No Canned Fish (fully-breastfeeding women only)	❑ No Yogurt	❑ No Eggs
❑ No Soy-Based Beverages		

C. WHOLE MILK — CHILD (24 MONTHS OF AGE OR OLDER) OR WOMAN

❑ Whole milk prescribed. Otherwise, these individuals receive skim/1%.

D. HEALTH CARE PROVIDER INFORMATION

Signature of health care provider:		
Provider's name (please print):		
Medical office/clinic (include address):		
Phone #:	**Fax #:**	**Date:**

Contact your local WIC program with any questions about current policy or for more information.