

# 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
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**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 ( $\leq$  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](http://www.michigan.gov/wic).**

**3. SUPPLEMENTAL FOODS:**

**All** (issue all allowed **age appropriate** WIC Foods starting at six months)  
 **For women/children  $\geq$  12 months old:** issue infant cereal & infant fruits/vegetables instead of cereal, fruits/vegetables  
 **Restriction (check foods to be OMITTED):**

<b>Infant (6-12 months)</b> <input type="checkbox"/> All (issue formula only) <input type="checkbox"/> Infant cereal <input type="checkbox"/> Infant fruits/vegetables	<b>Child (1-5 years) and Woman</b> <input type="checkbox"/> All (issue formula only) <input type="checkbox"/> Milk <input type="checkbox"/> Yogurt <input type="checkbox"/> Cheese <input type="checkbox"/> Eggs <input type="checkbox"/> Legumes	<input type="checkbox"/> Peanut Butter <input type="checkbox"/> Breakfast cereal <input type="checkbox"/> Bread, rice, tortilla, oatmeal, pasta <input type="checkbox"/> Fruits/vegetables <input type="checkbox"/> 100% fruit/vegetable juice <input type="checkbox"/> Canned fish (women only)
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**Instructions/Comments:** \_\_\_\_\_

**4. MILK SUBSTITUTIONS (optional): Medical Reason:** \_\_\_\_\_

**Whole Milk** (Honored only if medically indicated formula prescribed)  
 **2% Milk** (In place of  $\leq$  1% milk, woman/child  $\geq$  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)

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

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