Pennsylvania WIC Program
Formula Authorization Form

Client’s First & Last Name ___________________________ Birth Date ___________________________

Parent/Caregiver's First & Last Name ___________________________

1. Formula requested: ___________________________

   Amount requested: ___ oz/day (if formula) ___ Tbsp/day (if modular formula)

   Length of use: □ 1 month □ 3 months □ 6 months □ through this date ____________ (max 6 months)

   (Monthly renewal required for pre-discharge premature formulas. WIC encourages re-challenge with primary infant formula after solids have been introduced, generally at 6 months of age, with physician approval.)

   Via tube feeding? □ Yes □ No

   Special instructions for preparation and use (if necessary): ____________________________________________

2. Qualifying Medical Condition(s): ___________________________ ICD-10 Code: ___________________________

   (Justifies the prescription of above formula).

3. Are there any WIC food restrictions? □ Yes □ No

   If yes, please check the foods below that your client should not receive from WIC as well as length of restriction:

   Infants (6-11 months): □ infant cereal □ infant vegetable or fruit □ infant meat

   Children & Women: □ tofu □ soy beverage □ milk □ yogurt □ cheese

   □ juice □ breakfast cereal □ whole wheat bread or other whole grains

   □ eggs □ vegetables & fruits □ fish (tuna/salmon/sardines)

   □ legumes □ peanut butter (available after age 2 only)

   Length of restriction: □ 1 month □ 3 months □ 6 months □ other: ___________________________

   Reasons/Instructions/Comments: ____________________________________________

4. WIC authorizes the following types of milk and yogurt:

   a. whole fat milk and yogurt for children 12-23 months.

   Check box below if other than whole milk is indicated:

   milk: □ 2% □ 1% □ skim □ soy beverage □ tofu: 1-4 lbs: ___ > 4 lbs: ___ □ yogurt: low fat/non fat

   b. 1% or skim milk or lowfat/nonfat yogurt for women and children age 2 and over.

   Check box below if other than 1% or skim milk is indicated:

   milk: □ whole* □ 2% □ soy beverage □ tofu: 1-4 lbs: ___ > 4 lbs: ___ □ yogurt: whole fat

   * Whole milk may be provided for women and children age 2 and over, only if a special formula is prescribed.

Signature: ___________________________ Date: _______________

Physician, Certified Registered Nurse Practitioner, Certified Nurse Midwife, Physician Assistant

Printed Name: ___________________________

Medical Office/ Clinic: ___________________________ Telephone: _______________

Address: ___________________________ Fax: _______________

PA WIC is funded by the USDA.
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