Rhode Island Department of Health
Medical Documentation for WIC Formula and Approved WIC Foods

Infants & Children

Completion of this form is federally required to ensure that the patient under your care has a medical condition/diagnosis that requires the use of medical formula/food and/or changes to their supplemental food package.

A. Patient Information (Complete All)	
Patients Name:	**DOB:**
Parent/Guardian Name:	
Medical Diagnosis/Qualifying Condition(s):	
***** Please Note: The following non specific symptoms are not considered acceptable medical diagnosis: Constipation, Spitting Up, Colic, Crying, Gas, Fussiness, Intolerance, or Difficulty Feeding. Any request containing these diagnosis will NOT be accepted for special formula exemptions.**	

B. Medical Formula/Medical Food
Name of medical formula/medical food:
Prescribed amount: _____**oz per day**
Requested length of issuance: ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6 Months**

C. Supplemental Foods		
**In addition, supplemental foods will be issued for participants over 6 months of age, unless contraindicated. Please review and select the issuance appropriate for your patient:		
WIC foods allowed – *Infants 6-12 months* (Please select all that apply) ☐ **Baby food fruits & vegetables** ☐ **Infant cereal** ☐ **Infant unable to take other foods at this time**		
WIC foods allowed – *Children* (Please select all that apply)		
☐ **Juice**	☐ **Peanut Butter**	☐ **Fruits & Vegetables**
☐ **Eggs**	☐ **Cereal**	☐ **Cheese**
☐**Legumes**	☐ **Whole grain bread/other whole grains**	☐ **Milk****
** ☐ **Issue whole milk**: WIC provides 1% low fat milk for all children ☐ 2 years. Only participants who need additional calories may receive whole milk.		

D. Health Care Provider Information (Complete all)		
Provider's Name (please print):		
Signature of health care provider:		
Medical office/clinic:		
Phone:	**Fax#:**	**Date:**