

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

Complete sections A and F 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**.
- ▶ To prescribe **tofu** for a child (12 months of age or older) or a woman, also complete **section D**.
- ▶ To prescribe a **soy-based beverage** for a child (12 months of age or older), also complete **section E**.

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:		
<input type="checkbox"/> No Supplemental foods are allowed for this participant. Offering these foods is contraindicated at this time.		
— or —		
Identify <u>any</u> WIC supplemental foods <u>not</u> allowed for this participant, otherwise some or all of the following foods may be provided depending on the participant category.		
<input type="checkbox"/> No Milk	<input type="checkbox"/> No Juice	<input type="checkbox"/> No Breakfast Cereal
<input type="checkbox"/> No Whole-wheat Bread or Other Whole Grains	<input type="checkbox"/> No Eggs	<input type="checkbox"/> No Fruits and Vegetables
<input type="checkbox"/> No Cheese	<input type="checkbox"/> No Peanut Butter	<input type="checkbox"/> No Legumes
<input type="checkbox"/> No Canned Fish (fully-breastfeeding women only)		
C. Whole Milk — Child (24 Months of Age or Older) or Woman		
<input type="checkbox"/> Whole milk prescribed. Otherwise, these individuals receive skim, 1%, or 2% milk.		
D. Tofu — Child (12 Months of Age or Older) or Woman		
Allow tofu substitution. <input type="checkbox"/> Entire milk allowance <input type="checkbox"/> Part of milk allowance		
Please indicate the specific qualifying condition that justifies the need for tofu as a milk substitute.		
<input type="checkbox"/> Milk allergy <input type="checkbox"/> Severe lactose intolerance <input type="checkbox"/> Vegan diet <input type="checkbox"/> Other _____		
E. Soy-based Beverage — Child (12 Months of Age or Older)		
<input type="checkbox"/> Allow soy-based beverage substitution. All fluid milk substituted with soy-based beverage.		
Please indicate the specific qualifying condition that justifies the need for soy-based beverage as a milk substitute.		
<input type="checkbox"/> Milk allergy <input type="checkbox"/> Severe lactose intolerance <input type="checkbox"/> Vegan diet <input type="checkbox"/> Other _____		
F. Health Care Provider Information		
Signature of health care provider:		
Provider's name (please print):	Leamor Buenaseda, MD, FAAP	
Medical office/clinic (include address): Kids First Pediatrics of Raeford 4005 Fayetteville Road, Raeford, NC, 38376		
Phone #: 910-848-5437	Fax #: 910-848-5439	Date:

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