



New Jersey Department of Health  
WIC Services

**MEDICAL DOCUMENTATION FOR WIC FORMULA AND  
APPROVED WIC FOODS FOR INFANTS, CHILDREN AND WOMEN**

WIC Clinic	Phone	Fax
------------	-------	-----

**Please complete entire form. Fax the completed form to the WIC clinic or have your patient return the document to the WIC Clinic. Thank you!**

**PLEASE NOTE:** It is the responsibility of the health care provider to provide close medical oversight and instructions to participants issued exempt infant formula, WIC-eligible medical foods and/or supplemental foods that require medical documentation. This responsibility cannot be assumed by personnel at the WIC State or local agency.  
**Re-authorization is required every three months.**

- **No authorization is necessary for: Enfamil Infant, Enfamil Gentlease and Enfamil Prosobee**

Patient Name (First and Last)	Current Height/Length:
Date of Birth	Current Weight:
Parent/Caregiver Name (First and Last)	Date

1. Formula Requested: \_\_\_\_\_  
 Amount Requested:  Maximum Allowable OR  \_\_\_\_\_ ounces/day (if formula)  
 Physical Form:  Powder  Concentrate  
 Intended Length of Use:  1 Month  2 Months  3 Months

2. Qualifying Condition(s) (Justifies the medical need.) **(Complete and submit Page 2 with this form.)**  
 3. Can patient receive supplemental (or other WIC) foods in addition to formula or medical food?  Yes  No  
 (If Yes, please check the foods below that your patient **CAN/IS** eating.)

**Infants (6-11 months only):**

Infant Cereal  Infant Vegetable or Fruit

**Children and Women:**

Juice  Breakfast Cereal  Whole Wheat Bread or Other Whole Grains  Eggs  
 Vegetables and Fruits  Milk or Milk Substitutes  Legumes  Canned Fish\*  Peanut Butter

Reasons/Instructions/Comments: \_\_\_\_\_  
 \_\_\_\_\_

*\*Fully breastfeeding women, women partially breastfeeding multiple infants from the same pregnancy, women pregnant with multiple infants, and pregnant women who are mostly breastfeeding an infant are the only WIC participant categories eligible to receive these foods.*

Health Care Provider Name (Print)	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APN <input type="checkbox"/> PA-C
Medical Office/Clinic	Telephone Number
Medical Office/Clinic Address	Fax Number
Health Care Provider Signature	Date

**WIC OFFICE USE ONLY:**

Reviewed by CPA Name:	<input type="checkbox"/> Approved # of months: _____ <input type="checkbox"/> Disapproved	Date:	If required: MS and/or RD CPA Name:
-----------------------	---	-------	-------------------------------------

**MEDICAL DOCUMENTATION FOR WIC FORMULA AND  
APPROVED WIC FOODS FOR INFANTS, CHILDREN AND WOMEN**

**QUALIFYING CONDITIONS**

*(Please check appropriate Qualifying Conditions.)*

<b>Participant Category</b>	<b>Non-Qualifying Conditions</b>	<b>Qualifying Conditions</b>
<b>Infants (up to 12 months)</b>	<ul style="list-style-type: none"> <li>• Non-specific formula or food intolerance</li> <li>• Only condition is a diagnosed formula intolerance or food allergy to lactose, sucrose, milk protein or soy protein that does not require an exempt infant formula</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Severe food allergies</li> <li><input type="checkbox"/> Milk and soy allergies</li> <li><input type="checkbox"/> Metabolic disorders</li> <li><input type="checkbox"/> Gastrointestinal disorder</li> <li><input type="checkbox"/> Mal-absorption disorders</li> <li><input type="checkbox"/> Premature birth</li> <li><input type="checkbox"/> Failure to thrive/severely underweight</li> <li><input type="checkbox"/> Low birth weight</li> <li><input type="checkbox"/> NG/Tube Fed</li> <li><input type="checkbox"/> Oral/motor feeding problems</li> <li><input type="checkbox"/> Immune system disorders</li> <li><input type="checkbox"/> Life threatening disorders</li> </ul>
<b>Children (up to five years of age)</b>	<ul style="list-style-type: none"> <li>• Solely for the purpose of enhancing nutrient intake or managing body weight without an underlying condition</li> <li>• Lactose intolerance</li> <li>• Participant preference</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Severe food allergies</li> <li><input type="checkbox"/> Milk and soy allergies</li> <li><input type="checkbox"/> Metabolic disorders</li> <li><input type="checkbox"/> Gastrointestinal disorder</li> <li><input type="checkbox"/> Mal-absorption disorders</li> <li><input type="checkbox"/> Premature birth</li> <li><input type="checkbox"/> Failure to thrive/severely underweight</li> <li><input type="checkbox"/> Low birth weight</li> <li><input type="checkbox"/> NG/Tube Fed</li> <li><input type="checkbox"/> Oral/motor feeding problems</li> <li><input type="checkbox"/> Immune system disorders</li> <li><input type="checkbox"/> Life threatening disorders</li> </ul>
<b>Women</b>	<ul style="list-style-type: none"> <li>• Solely for the purpose of enhancing nutrient intake or managing body weight without an underlying condition</li> <li>• Lactose intolerance</li> <li>• Participant preference</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Severe food allergies</li> <li><input type="checkbox"/> Milk and soy allergies</li> <li><input type="checkbox"/> Metabolic disorders</li> <li><input type="checkbox"/> Gastrointestinal disorder</li> <li><input type="checkbox"/> Mal-absorption disorders</li> <li><input type="checkbox"/> NG/Tube Fed</li> <li><input type="checkbox"/> Oral/motor feeding problems</li> <li><input type="checkbox"/> Immune system disorders</li> <li><input type="checkbox"/> Life threatening disorders</li> </ul>