



## Arizona WIC Special Formula Authorization Form Children, Women and Healthy Infants

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ WIC Client ID: \_\_\_\_\_

*Please fully complete every section (1-7) to avoid delays in issuance.*

**1. Formula(s) Previously Tried:**

**WIC contract formula as noted by “\*\*”:**

- Similac Advance EarlyShield
- Similac Soy Isomil
- Similac Sensitive for Fussiness & Gas
- Other:** \_\_\_\_\_

**3. Amount of Formula Requested Per Day:** \_\_\_\_\_

(Ad lib is an acceptable response)

- Oral       Tube Feeding

**Please choose WIC contract formulas whenever possible, as noted by “\*\*”.**

**2. Current Formula Request:**

- Similac Advance EarlyShield\*
- Similac Soy Isomil\*
- Similac Sensitive for Fussiness & Gas\*
- Similac Go & Grow\*
- Similac Go & Grow Soy\*
- Similac for Spit-Up
- Pediasure (must meet WIC criteria for issuance)
- Other:** \_\_\_\_\_

**Form of Formula:**    Powder     Concentrate     Ready-to-feed

**4. Diagnosis for Special Formula or Medical Food:**

- Prematurity       GERD or reflux       Dysphagia       Failure to thrive (<5th percentile wt/length or BMI/age)
- Food allergy: \_\_\_\_\_       Other: \_\_\_\_\_

**Note:** Must be a specific medical diagnosis.

**5. WIC Food Restrictions:** *Please check any foods listed below that are NOT appropriate for the diagnosis.*

**Note:** Infant <6 mo will not receive foods.

- All foods are appropriate **OR**

Category	WIC Foods	Do <u>Not</u> Give	Comments
Infants (6-11 mo.)	Infant cereal	<input type="checkbox"/>	_____
	Infant Jarred-fruits/vegetables	<input type="checkbox"/>	_____
Children (1-5 yr.) and Women	Cow's milk	<input type="checkbox"/>	_____
	Cheese	<input type="checkbox"/>	_____
	Eggs	<input type="checkbox"/>	_____
	Peanut butter	<input type="checkbox"/>	_____
	Whole grains**	<input type="checkbox"/>	_____
	Cereal	<input type="checkbox"/>	_____
	Beans	<input type="checkbox"/>	_____
	Vegetables/fruits	<input type="checkbox"/>	_____
	Juice	<input type="checkbox"/>	_____
	Soy milk	<input type="checkbox"/>	_____
Tofu	<input type="checkbox"/>	_____	
Exclusively Nursing Women	Canned Fish	<input type="checkbox"/>	_____

*\*\*Grains include the options of whole wheat bread, brown rice, and/or corn tortillas.*

**6. Length of Time Requested:** # months (circle): 1   2   3   4   5   6   **OR** # weeks: \_\_\_\_\_

**7. Print Provider Name/Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Healthcare Provider Signature:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Local Nutritionist/State Approval**

Approved       Not Approved      Length of Authorization: From \_\_\_\_\_ To \_\_\_\_\_

Comments: \_\_\_\_\_

Signature: \_\_\_\_\_