SOUTH DAKOTA DEPARTMENT OF HEALTH WIC PROGRAM
MEDICAL DOCUMENTATION FORM

Participant's Name: ____ **Date of Birth:** ________________

Parent/Guardian's Name: ____ **Request Date:** ________________

REQUIRED COMPLETION

_____ Asthma
_____ Carbohydrate Intolerance
_____ Failure to Thrive
_____ GI Disorders
_____ Malabsorption Syndromes
_____ Metabolic Disorders
_____ Inborn Errors of Metabolism
_____ Protein Allergies (e.g. cow's milk or soy protein)
_____ Reflux
_____ Renal Disease
_____ Prematurity

"Formula Intolerance" and Intolerance Symptoms <u>will not</u> be accepted.
Other: Please enter diagnosis description rather than ICD-10 Code:____

<u>Formula Requested (Please circle one)</u>

Enfamil Infant   Enfamil ProSobee   Enfamil Gentlease   Enfamil AR   Enfagrow Premium   Enfagrow Soy

Other Formula Requested: ____

Prescribed Amount: ☐ Maximum Amount Allowable -OR- ______ oz/day

___ Issue whole milk (Only participants receiving infant formula, exempt infant formula or WIC-eligible nutritionals qualify)

<u>Supplemental Foods:</u> (ALL foods will be provided unless items are checked)

__ Refer to the WIC Registered Dietitian for supplemental foods

__Issue **<u>NO</u>** WIC supplemental foods; provide formula only

☐ **SELECT** the supplemental food(s) below and provide instructions/comments:

Infants (6 through 12 months): __ Infant Cereal   __Baby Food Fruits/Vegetables   __Baby Food Meats

Children (1 through 4 years old) and Women:

__ Milk other than standard
* Whole milk for children 12 – 23 months
* 1% and skim/nonfat milk for women and children $\geq$2 years

__Cheese   __Cereal   __Juice   __Eggs   __Beans/Peas   __Whole Wheat Bread/Brown Rice/Tortillas
__Peanut Butter   __Fruits/Vegetables   __Tuna/Salmon/Sardines   __ Jarred infant fruits/vegetables

Special Instructions/Comments: ____

Medical Documentation Approval Time: ☐ 3 mo   ☐ 6 mo

Signature of Health Care Provider: ____ **Date:** ______________

Health Care Provider's Name: ____ ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA**

Clinic/Address: ____

Phone Number: ______________________________ **Fax Number:** ______________________________

FOR WIC USE ONLY

Amount to be issued to participant monthly__________   **Months medical documentation is approved:**

JAN   FEB   MAR   APR   MAY   JUNE   JULY   AUG   SEPT   OCT   NOV   DEC

Approval Signature____**Date**____________________