

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

**"Formula Intolerance" and Intolerance Symptoms will not be accepted.**

Other: Please enter diagnosis description rather than ICD-9 Code: \_\_\_\_\_

**Formula Requested (Please circle one)**

Enfamil LIPIL    Enfamil ProSobee LIPIL    Enfamil Gentlease    Enfamil AR    Enfagrow Premium    Enfagrow Soy

**Other Formula Requested:** \_\_\_\_\_

**Prescribed Amount:**  Maximum Amount Allowable -OR- \_\_\_\_\_ oz/day

**Supplemental Foods: (If nothing is checked, ALL foods will be given)**

Issue **NO** WIC supplemental foods; provide formula only

**OMIT** the supplemental foods checked below:

**Infants (6 through 12 months):**     Infant Cereal     Baby Food Fruits/Vegetables     Baby Food Meats

**Children (1 through 4 years old) and Women:**

- Milk (WIC provides 2%, 1%, and skim milk for women and children  $\geq 2$  years of age.)     Cheese     Cereal     Juice  
 Eggs     Beans/Peas     Whole Wheat Bread/Brown Rice/Tortillas/Oatmeal     Peanut Butter     Fruits/Vegetables  
 Tuna/Salmon/Sardines  
 Issue whole milk: Only participants receiving non contract formula qualify to receive whole milk.

**Special Instructions/Comments:** \_\_\_\_\_

**COMPLETE IF PARTICIPANT NEEDS MILK SUBSTITUTE(S)**

**Milk Substitute(s) Requested:**  > 1 pound cheese for women or children (fully breastfeeding women > 2 pounds)

Soy beverage for children.

**Qualifying Condition:**     Milk Allergy     Severe Lactose Intolerance     Cultural Preferences (Religious/Vegan)

Underweight ( $\leq 5^{\text{th}}$  %tile wt/length or BMI for children or underweight BMI for women)     Other: \_\_\_\_\_  
(Personal preference is not an allowed reason)

**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** \_\_\_\_\_