Version 10.2025

# Nevada WIC Medical Documentation Form

Nevada WIC provides the following standard formula: Similac Advance, Similac Sensitive, Similac Total Comfort, Similac Isomil. **Nevada WIC cannot provide the following formulas, even with medical documentation:** Enfamil Infant, Gentlease, Sensitive and ProSobee; Enfamil Enspire line; Enfamil NeuroPro line; Similac 360 Total Care/Sensitive (powder); Similac Pro-Total Comfort; Gerber Good Start Gentle/Pro, SoothePro and Soy.

## SECTION I: PARTICIPANT INFORMATION

Participant Name: _____ Date of Birth (DOB): _____

Parent/Guardian Name:_____ Phone Number: _____

## SECTION II: SPECIAL FORMULA/NUTRITIONALS AND SUPPLEMENTAL FOODS

**Part A) Qualifying Medical Condition (MANDATORY)**

□ Premature ≤ 37 weeks gestation (P070.3)
□ Failure to thrive (R62.51)
□ Extremely low birth weight newborn (P07.00)
□ Severe food allergy (specify):
_____
□ Metabolic disorder/Inborn errors of metabolism (specify) _____
□ Malabsorption syndromes/GI disorders (specify):
_____
□ Other medical condition that impairs nutrition status (specify):
_____

*Non-specific symptoms such as milk/formula intolerance, fussiness, colic, spitting up, gas, constipation or picky eating are **not** considered acceptable medical diagnoses/conditions for special formula and will not be approved. WIC **cannot** provide special formula to enhance nutrient intake or manage body weight without an underlying medical condition.*

**Part B) Special Formula (All 4 questions are MANDATORY)**

(1) **Formula requested:** _____ (2) Formula Type: □Powdered □Concentrate □RTF

(3) **Prescribed ounces/day:** _____ ***OR*** □Max allowed (4) **Duration:** □3 months □6 months □Until 12 months old

**Part C) Supplemental Foods (optional)**

□ I authorize the WIC Nutritionist to determine appropriate issuance of supplemental foods.
□ I **DO NOT** authorize the WIC Nutritionist to determine appropriate issuance of foods. Select all that apply:

Infants 6-12 months

□ Formula **ONLY**. No infant foods and increased amount of formula due to inability or delay in consuming solids.

**OMIT** – foods checked here need to be removed from food package:

□ Infant Cereal
□ Infant Fruits and Vegetables
□ Infant Meats

Child/Woman

□ Provide whole milk for woman/child ≥ 2 yrs (qualifying medical condition required above).

□ Provide **baby foods** due to medical condition instead of cereal and/or fruits and vegetables.

□ **Do not provide foods**. Medical formula only.

**OMIT** – Foods checked here need to be removed from participants food package:

□ Eggs □ Juice □ Peanut Butter □ Cheese □ Beans □ Cereal □ Milk
□ Yogurt □ Whole Grains □ Fruits/Veggies □ Canned Fish

**Part D) Data from participant's most recent doctor's appointment:** Date of appointment: _____

Height/Length: _____ inches Weight: _____lb. _____oz Lead: _____ Hemoglobin: _____

Special Instructions: _____

## SECTION III: HEALTH CARE PROVIDER INFORMATION (May be printed or stamped. Original signature required.)

Providers Name (please print):
_____

Providers signature: Date:
_____ _____

Medical Office: _____
Address:_____
_____
Phone:_____
Fax: _____

This institution is an equal opportunity provider.