Form also available at:
wcdwic.org/health-care-providers

ITO WIC Exception Request for Formula or Food

All sections of this federally required form must be completed for consideration to approve the use of WIC-eligible special formula or medical food for a woman, infant or child under your care.

Participant Name: _____ DOB: _____

If premature: Weeks Gestation _____ Birth Weight: _____

Qualifying Medical condition(s): _____

Non-specific symptoms are NOT acceptable for issuance of non-contract formulas. *Symptoms include milk/formula intolerance manageable w/other contract formula, fussiness, colic, spitting up, gas, constipation, diarrhea, picky eating, parental preference.*

*WIC **cannot** provide special formula or higher percent fat milks to enhance nutrient intake or manage body weight without an underlying medical condition.*

Weight: _____ Length/height: _____ Date taken (within 60 days of request): _____

Formula or Medical Food Requested: _____

Amount: ☐ _____ per day OR ☐ Maximum allowed Duration: ☐ 1 month ☐ 2 months ☐ 3 months

Special Instructions (if any): _____

Mark any contraindicated foods. All WIC foods will be provided unless indicated below.

Infants 6-11 months

☐ No Infant Fruits/Vegetables

☐ No Infant Cereal

☐ No Fresh Fruits/Vegetables (9-11 mo. only)

Women and Children

☐ No Eggs

☐ No Breakfast Cereal

☐ No Peanut Butter

☐ No Beans

☐ No Whole Grains

☐ No Fruits and Vegetables

☐ No Fish (fully BF women only)

☐ No Milk

☐ No Cheese

☐ No Yogurt

☐ No Soymilk

☐ No Tofu

☐ No Juice

Women and Children requiring infant (pureed) foods

☐ Sub Infant Fruits/Vegetables for Fresh Fruits/Vegetables ☐ Sub Infant Cereal for Breakfast Cereal

Signature of Healthcare Provider: Date:

Provider Name (print): ☐ MD ☐ DO ☐ PA ☐ APRN

Medical Office/Clinic:

Phone: Fax: Email:

WIC Staff Use Only

Reviewing RD's Signature: Date:

Approved: ☐ Yes ☐ No For Issuance Months:

WIC Clinic: Phone: Fax: