

Alabama WIC Child Prescription for Soy Milk

Prescription is subject to WIC Approval based on Program Policy and Procedure

Date _____

Patient's Name _____ Date of Birth _____

Soy milk will replace all of the child's milk/cheese allowance provided by the Alabama WIC Program.

Qualifying Condition(s) (required)

This child (12 months through 4 years of age) cannot drink cow's milk due to:

Milk Allergy Severe lactose maldigestion Vegan Other _____

Intended Length of Use:

12 months through 4 years of age

Signature of Health Care Provider: _____

Provider's Name (Please print): _____

Phone: (____) _____ Fax: (____) _____

If you have questions please call your local WIC clinic.

CLINIC STAMP
Local Agency: _____
Address: _____
Phone: _____

WIC Clinic Use Only
CHR# _____ Date Received _____ Approved By _____

Alabama WIC Child Prescription for Soy Milk (ADPH-WIC-111c)

Instructions for Completion of Form

Important – Only this form will be accepted by WIC clinics for soy milk requests for children.

Date: Enter date form is being completed.

Patient's Name: Enter name of the patient requiring soy milk.

Date of Birth: Enter the patient's date of birth.

Qualifying Condition(s): Document the qualifying condition(s) justifying soy milk as a milk and cheese substitute.

Intended Length of Use: Check the time period that soy milk is needed.

Signature of Health Care provider: The health care provider's signature must be entered.

Provider's Name, printed: PRINT the health care provider's name.

Phone: Enter the health care provider's phone number.

Fax: Enter the health care provider's fax number.

Clinic Stamp: WIC clinic completes as needed: Use a local agency stamp to provide this information or complete by hand.

WIC Clinic Use Only: Information is required to be completed.

CHR#: Enter the patient's CHR number.

Date Received: Enter the date the clinic receives the prescription form.

Approved by: Enter the name of the person approving the acceptance of the prescription.