BALTO CO HEALTH DEPT

WIC Fax: _____
Date Form Expires: __/__/__

Maryland WIC

Better Nutrition Brighter Future
1-800-242-4942 | www.mdwic.org

Breastfeeding is Baby's Best Start

Medical Documentation Form: Sections 1-4 MUST be completed.

Infants not exclusively breastfed are provided Similac Advance or Similac Soy Isomil. This form is federally required to request an exempt infant formula/WIC-eligible nutritional for qualifying medical conditions. All requests are subject to WIC approval. Please contact the Local WIC clinic (see back of form) or the State WIC Office at 1-800-242-4942 with any questions.

1) REQUIRED: Patient Information

Patient Name: _____ **Patient DOB:** __/__/__

Parent/Guardian: _____

Participant Medical Data (optional):	Weight:	Length/height:	Hgb: Hct:
Date Measured:	__/__/__	__/__/__	__/__/__

2) REQUIRED: Exempt Infant Formula/WIC-Eligible Nutritional Request

Medical diagnosis: _____ **Symptoms:** _____

Non-specific symptoms such as intolerance, fussiness, colic, spitting up, gas and constipation will NOT be considered medical diagnoses for exempt infant formulas/WIC-eligible nutritionals.

Product: _____

Calorie Level:
☐ Standard dilution ☐ Other: _____

Amount per day:
☐ WIC maximum ☐ Other: _____

Duration: ☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other

3) REQUIRED: WIC Food Requests (Check all that apply)

- ☐ WIC professional may determine WIC foods and amounts.
- ☐ Issue formula/WIC-eligible nutritional only.
- ☐ Whole milk for a woman or child (≥ 2 years).
- ☐ Issue infant fruits and vegetables to a woman or child.
- ☐ Issue soy beverage and/or tofu to replace milk.
- ☐ Issue WIC foods and amounts without changes to the standard food package.
- ☐ Do NOT issue (comment required): _____

4) REQUIRED: Health Care Provider with Prescriptive Authority:

(MD, DO, PA, NP/CNP/CRNP/DNP, APN, CNM, CRNA, CNS, MBBS, MBBCh)

Name: (Please print, type or stamp)_____

Phone: _____ Fax: _____

Signature and Credentials: _____ Date: __/__/__

WIC use only: ☐ Approved ☐ Not Approved ☐ Pending

Signature: _____ Date: __/__/__

Comments:

Website: www.mdwic.org. Click on the Health Care Providers section for more information.

MARYLAND STATE DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE
MEDICATION ADMINISTRATION AUTHORIZATION FORM

Child's Picture (Optional)

Child Care Program: _____

This form must be completed fully in order for child care providers and staff to administer the required medication. A new medication administration form must be completed at the beginning of each 12 month period, for each medication, and each time there is a change in dosage or time of administration of a medication.

- **Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **Non-prescription medication must be in the original container with the label intact.**
- **Parent/Guardian must bring the medication to the facility.**
- **Must pick up the medication at the end of authorized period, otherwise it will be discarded.**

PRESCRIBER'S AUTHORIZATION

Child's Name: _____ Date of Birth: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____ (PRN=as needed)

If PRN, for what symptoms: _____

Possible side effects &special Instructions: _____

Medication shall be administered from: _____ (Month / Day / Year) to _____ (Month / Day / Year (not to exceed 1 year))

Known Food or Drug: Allergies? Yes No If Yes, please explain _____

Prescriber's Name/Title: _____ (Type or print)

Telephone: _____ FAX: _____

Address: _____

Prescriber's Signature: _____ Date: _____ (Original signature or signature stamp ONLY)

This space may be used for the Prescriber's Address Stamp

PARENT/GUARDIAN AUTHORIZATION

I/We request authorized child care provider/staff to administer the medication as prescribed by the above prescriber. I attest that I have administered at least one dose of the medication to my child without adverse effects. I/We certify that I/we have legal authority, understand the risk and consent to medical treatment for the child named above, including the administration of medication. I agree to review special instruction and demonstrate medication administration procedure to the child care provider.

Parent/Guardian Signature: _____ Date: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

SELF CARRY/SELF ADMINISTRATION OF EMERGENCY MEDICATION AUTHORIZATION/APPROVAL

(Only school-aged children may be authorized to self carry/self administer medication.)

Self carry/self administration of **emergency** medication noted above may be authorized by the prescriber.

Prescriber's authorization: _____ (Signature) _____ (Date)

Parental approval: _____ (Signature) _____ (Date)

FACILITY RECEIPT AND REVIEW

Medication was received from: _____ Date: _____

Special Heath Care Plan Received: ☐ YES ☐ NO

Medication was received by: _____ (Signature of Person Receiving Medication and Reviewing the Form) _____ (Date)