Minnesota WIC Program
Authorization of Milk Substitute

Date:
To:
Fax:

Federal WIC Regulations require medical authorization from a Health Care Provider in order to provide certain milk substitutes. The food being requested is marked below.

- Please indicate the reason the milk substitute is required. If there are any contraindications to the food requested below, please indicate why.
- This approval is valid for 1 year from date of signature unless otherwise noted.

Participant's Name: _____ **Date of Birth:** _____
(last name) (first name)

Parent/Caregiver: _____ **Telephone:** _____
(last name) (first name)

REQUESTED MILK SUBSTITUTE: **NOTE: Lactose-free milk is available with no authorization necessary.**

☐ **Soy Beverage:** if requesting for a child

☐ **Tofu:** if requesting any amount for a child, or
> 4 lbs. tofu for a pregnant or postpartum woman, or
> 6 lbs. tofu for a fully breastfeeding woman

INDICATE THE REASON THE MILK SUBSTITUTE IS REQUIRED:

☐ Milk allergy

☐ Severe lactose maldigestion (cannot tolerate lactose-free milk)

☐ Vegan/Vegetarian diet

☐ Medical condition requiring use of soy-based beverage/food
Please specify the conditon: _____

☐ Religious or cultural observance/practice

☐ Do not provide milk substitute. *Please specifiy why:* _____

Indicate any
SPECIAL INSTRUCTIONS:

SIGNATURE (Health Care Provider): _____ **Date:** _____

Printed Name (Health Care Provider): _____ ☐ MD ☐ DO ☐ NP ☐ CNM ☐ PA

Medical Office/ Clinic: _____ **Telephone:** _____

Address: _____ **Fax:** _____

RETURN COMPLETED FORM TO:

Fax Number _____ Attention _____ Phone _____

OR Mail to: _____

01/11

This institution is an equal opportunity provider.