Formula Approval Form

Local Agency #:	Clinic Site #:	Staff Collecting Information:
Participant's Name:		
DOB:	Birth Weight: lbs ounces	If premature, weeks gestation:

Date of most recent measurement:	Weight: lbs ounces	Length/Height: inches
Wt-for-Length/Ht or BMI-for-Age:	Weight-for-Age: Adjusted for Prematurity: Y N	Length-for-Age: Adjusted for Prematurity: Y N

Formula Requested:	Cans or Ounces Requested:	Requested Length of Issuance:
Formula History and Reactions:		
Diagnosis/medical condition (signs or symptoms):		
Diet Recall:		
Medications:		
Plan/Recommendations for next issuance:	Referrals:	

Approved Length of Issuance:		Expiration Date:
Food Package Code:	Formula Code:	If not max amount, amount issued:
Foods omitted, if applicable:		

If formula Denied, reason(s) for denial:	Notified Dr: Y N Comments:

Name of Approving Authority:	Today's Date:
State Approval Per:	SA Problem #:

Last updated: 7/10

Date	Additional Notes

Last updated: 7/10