



New Jersey Department of Health and Senior Services
WIC Services

MEDICAL DOCUMENTATION FOR MILK SUBSTITUTES

Client Name (First and Last)	Date of Birth
Parent/Caregiver Name (First and Last)	

PLEASE NOTE: No authorization/documentation is needed for lactose-reduced or lactose-free milk!

WIC Provides Children (Ages 1–5 Years) with COW’S MILK

- **Whole milk (For Ages 1-2 Years)**
 - **Low-fat milk (For Children >2 Years)**
1. Please check authorized substitutes to give in place of cow’s milk:
 >1 Pound of Cheese/Month Soy Beverage or Tofu
 2. Specify for how long the substitution is needed:
 3 Months 6 Months
(Milk substitutes can be requested for up to a six-month period. Health care providers must submit a new request form at the end of each approval period to continue milk substitutes in the food package).
 3. Reason for Substitution (Qualifying condition):
 Milk Allergy Severe Lactose Mal-digestion Vegan Diet Participant Preference

WIC provides Women with COW’S MILK or SOY BEVERAGE

1. Please check authorized substitutes to give in place of cow’s milk or soy beverage:
 >1 Pound of Cheese/Month* 4 Lbs. of Tofu/Month*
2. Specify for how long the substitution is needed:
 3 Months 6 Months
(Milk substitutes can be requested for up to a six-month period. Health care providers must submit a new request form at the end of each approval period to continue milk substitutes in the food package).
3. Reason for Substitution (Qualifying condition):
 Milk Allergy Severe Lactose Mal-digestion Vegan Diet Participant Preference

***Note:**

- **WIC women participants can request some cheese and tofu without needing medical documentation.**
- **Fully breastfeeding women, pregnant women with multiple infants, and women partially breastfeeding more than one infant can get up to 2 lbs. of cheese and 6 lbs. of tofu without needing medical documentation.**

Health Care Provider Name (Print)	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APN
Medical Office/Clinic	Telephone Number
Medical Office/Clinic Address	
Health Care Provider Signature	Date

WIC OFFICE USE ONLY:	Reviewed by CPA Name:	<input type="checkbox"/> Approved # of months: _____	Date:
		<input type="checkbox"/> Disapproved	