**Infant Formula Form**

**Program Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Classroom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Infant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please check your preferences below

[ ] **Formula** [ ] **Breast Milk**

[ ] I want the center/provider to provide **WIC approved** formula for my infant.

[ ] I will provide (Type) formula for my infant.

[ ] I will provide breast milk for my infant.

[ ] **I understand that I need to submit a Special Diet Statement and need approval of the Nutrition Manager if I provide a Low-Iron Formula or other Special Formula for my infant.)**

[ ] **I understand that at any time I wish to change this form it can be done so per request of the nutrition program through my provider.**

**Parent Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_**

**Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADMIN use only:**

**Reviewed by CACFP Initial: \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

**Plan Expires on \_\_\_\_\_\_\_\_**

**This institution is an equal opportunity provider.**