STAFF COMMUNICATION FORM

Client_________________________________________

BREASTFEEDING:  EB  FF  MBF  SBF  Mother’s Food Pkg Code:___________

Formula Code:  ____________
Infant Food Pkg Code: ____________

Infant Quantity per Issuance Month:*  

0  <1  1  2  3  4  5  6  7  8  9  10  11

*note: Formula issuance screen for infants born on the first day of the month will differ. Omit the <1 month.

FORMULA
 □ Issuing Formula with EBT + Stock for current month
 □ Formula Exchange
 □ Reminder: PRINT SCREEN

<table>
<thead>
<tr>
<th>Formula Code</th>
<th>Name of Formula</th>
<th>Return in Hand</th>
<th>New Qty</th>
<th>Issue from Stock</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

□ New Formula Name: _______________________________  Code: ____________
Rx Expiration Date: ___________________ Quantity per month:___________

□ Change Contract Formula from ___________________ to ___________________  New code: ________

FOOD PACKAGE

□ New Food Package Code: ____________

□ Customized Food Package:
Line item Delete the following foods:

Infants (6–11 months)
 □ Infant cereal
 □ Infant food

Children (1–5 Years) and Women
 □ Milk  □ Eggs  □ Cereal  □ Juice  □ Beans
 □ Cheese  □ Peanut butter  □ Whole grain  □ Fruits/Vegetables

NEXT APPOINTMENT FOR:  CL  SC  PC  BFPC  RD  OTHER__________  (CIRCLE ONE)

CERTIFYING AUTHORITY INITIALS ____________  DATE:___________________