More Information Available?	

Additional Comments

Section B - Product Availability

Do you still have the product in case we need to evaluate it?	No
Do you have a picture of the product? (check yes if you are including a picture)	Yes

Section C - About the Products 1 of 1

Suspect	Yes		
Primary?	Yes		
Type	Drug/Biologic		
This report is about	Food/Medical food		
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Apple cinnamon fruit puree		
Name of the company that makes (or compounds) the product	Wana bana		
Product Type(check all that apply)	☐ Over-the-Counter ☐ Compounded by a Pharmacy or an Outsourcing Facility ☐ Generic ☐ Biosimilar		
Strength		If Other	
NDC number			
Did the problem stop after the person reduced the dose or stopped taking or using the product?	No		
Did the problem return if the person started taking or using the product again?	Doesn't Apply		

Drug Therapy 1 of 1

Expiration date			
Lot number			
Dosage Form			
Quantity		If Other	
Frequency	Twice a day	If Other	
How was it taken or used	Oral	If Other	
Date the person first started taking or using the product	20-Oct-2021		
Date the person stopped taking or using the product	07-Nov-2023		

	Date the person reduced dose of the product	
	Give best estimate of duration	
	Is therapy still on-going?	

Why was the person using the product? (such as what condition was it supposed to treat) 1 of 1

	Favorite apple sauce

	Returned to Manufacturer On	

Section D - About the Medical Device

	Name of medical device	
	Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

	Model Number	
	Catalog Number	
	Lot Number	
	Serial Number	
	UDDI Number	
	Expiration date	
	Was someone operating the medical device when the problem occurred?	

For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	

Section E - About the Person Who Had the Problem

	Person's Initials	(b)(6)
	Sex	Male
	Gender	Cisgender man/boy
	Please Specify Other Gender	
	Age (specify unit of time for age)	
	Date of Birth	(b)(6)
	Weight	16.65 kg
	Ethnicity (Choose only one)	Not Hispanic/Latino
	Race (Check all that apply)	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian

	☐ White ☑ Black or African American

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

N/A

Please list all allergies (such as to drugs, foods, pollen or others)

N/A

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

List all current prescription medications and medical devices being used.

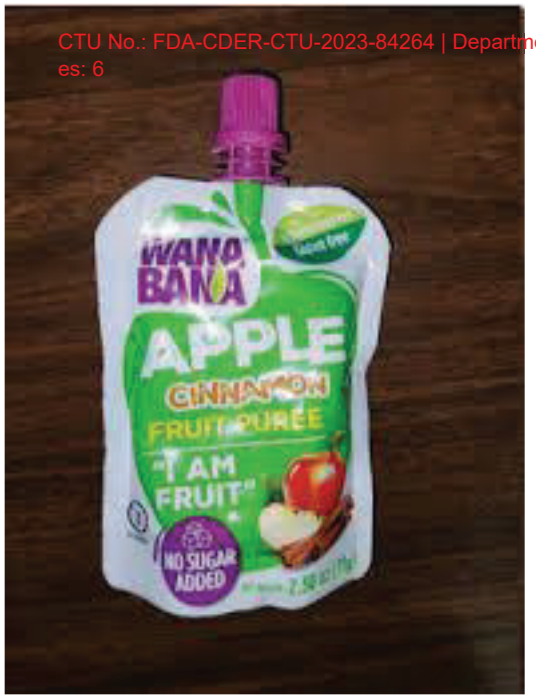
List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

Cilantro heavy metal detox

Section F - About the Person Filling Out This Form 1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b)(6)
Middle Name	
First name	(b)(6)
Number/Street	
City	
State/Province	
Country	UNITED STATES
ZIP or Postal code	(b)(6)
Telephone number	
Email address	

	Fax		
	Reporter Organization		
	Department		
	Reporter Speciality		
	Today's date	15-Nov-2023	
	Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No	
	If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No	


WANA BANA
APPLE
CINNAMON
FRUIT PUREE
"I AM FRUIT"
NO SUGAR ADDED

All dates displayed in the report are in EST(GMT-05:00) time zone

Basic Details

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	15-Nov-2023	CTU Received Date	15-Nov-2023
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	☑ CDER (CDER-OSE-RSS-CTU@fda.hhs.gov) (E2B)		
Case Priority	Direct		

Contact

Case Reporter	First Name	Last Name	Email Address	Phone
☑	(b)(6)	(b)(6)	(b)(6)	(b)(6)

Section A - About the Problem

What kind of problem was it? (Check all that apply)	☑ Were hurt or had a bad side effect (including new or worsening symptoms) ☐ Used a product incorrectly which could have or led to a problem ☐ Noticed a problem with the quality of the product ☐ Had problems after switching from one product maker to another maker
Date the problem occurred	29-Oct-2023
Serious	No
Did any of the following happen? (Check all that apply)	☐ Hospitalization - admitted or stayed longer ☑ Required help to prevent permanent harm ☐ Disability or health problem ☐ Birth defect ☐ Life-threatening ☐ Death ☐ Other serious/important medical incident(Please Describe Below)

4.Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

My son has consumed some apple puree packages and isn't feeling too well. Vomiting and has since been complaining of headaches. We checked packaging and it's a product just recalled for lead contamination. Ours matched the names and batch # of contaminated product. He only consumed two boxes of three packets but when tested he is showing elevated lead in his blood.

Relevant Test/Laboratory Data 1 of 1

	Test Name	LEAD PANEL	Test Date	09-Nov-2023
	Test Result	Positive for lead	Test Unit	
	Low Test Range		High Test Range	
	More Information Available?			

Additional Comments

Section B - Product Availability

Do you still have the product in case we need to evaluate it?	No
Do you have a picture of the product? (check yes if you are including a picture)	Yes

Section C - About the Products 1 of 1

Suspect	Yes		
Primary?	Yes		
Type	Drug/Biologic		
This report is about	Food/Medical food		
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Cinnamon Apple Puree		
Name of the company that makes (or compounds) the product	WanaBana		
Product Type(check all that apply)	☐ Over-the-Counter ☐ Compounded by a Pharmacy or an Outsourcing Facility ☑ Generic ☐ Biosimilar		
Strength		If Other	
NDC number			
Did the problem stop after the person reduced the dose or stopped taking or using the product?	No		
Did the problem return if the person started taking or using the product again?			

Drug Therapy 1 of 1

Expiration date	09-Jul-2024		
Lot number	05023:09		
Dosage Form			
Quantity		If Other	
Frequency	Daily	If Other	
How was it taken or used		If Other	
Date the person first started taking or using the product			
Date the person stopped taking or using the product			
Date the person reduced dose of the product			

	Give best estimate of duration	
	Is therapy still on-going?	

Why was the person using the product? (such as what condition was it supposed to treat) 1 of 1

	Returned to Manufacturer On	

Section D - About the Medical Device

	Name of medical device	
	Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

	Model Number	
	Catalog Number	
	Lot Number	
	Serial Number	
	UDDI Number	
	Expiration date	
	Was someone operating the medical device when the problem occurred?	

For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	

Section E - About the Person Who Had the Problem

	Person's Initials	(b)(6)
	Sex	Male
	Gender	Cisgender man/boy
	Please Specify Other Gender	
	Age (specify unit of time for age)	
	Date of Birth	(b)(6)
	Weight	41.4 kg
	Ethnicity (Choose only one)	Not Hispanic/Latino
	Race (Check all that apply)	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☑ White ☐ Black or African American

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)
Autism Spectrum, ADHD, sensory processing disorder

Please list all allergies (such as to drugs, foods, pollen or others)
Unknown

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

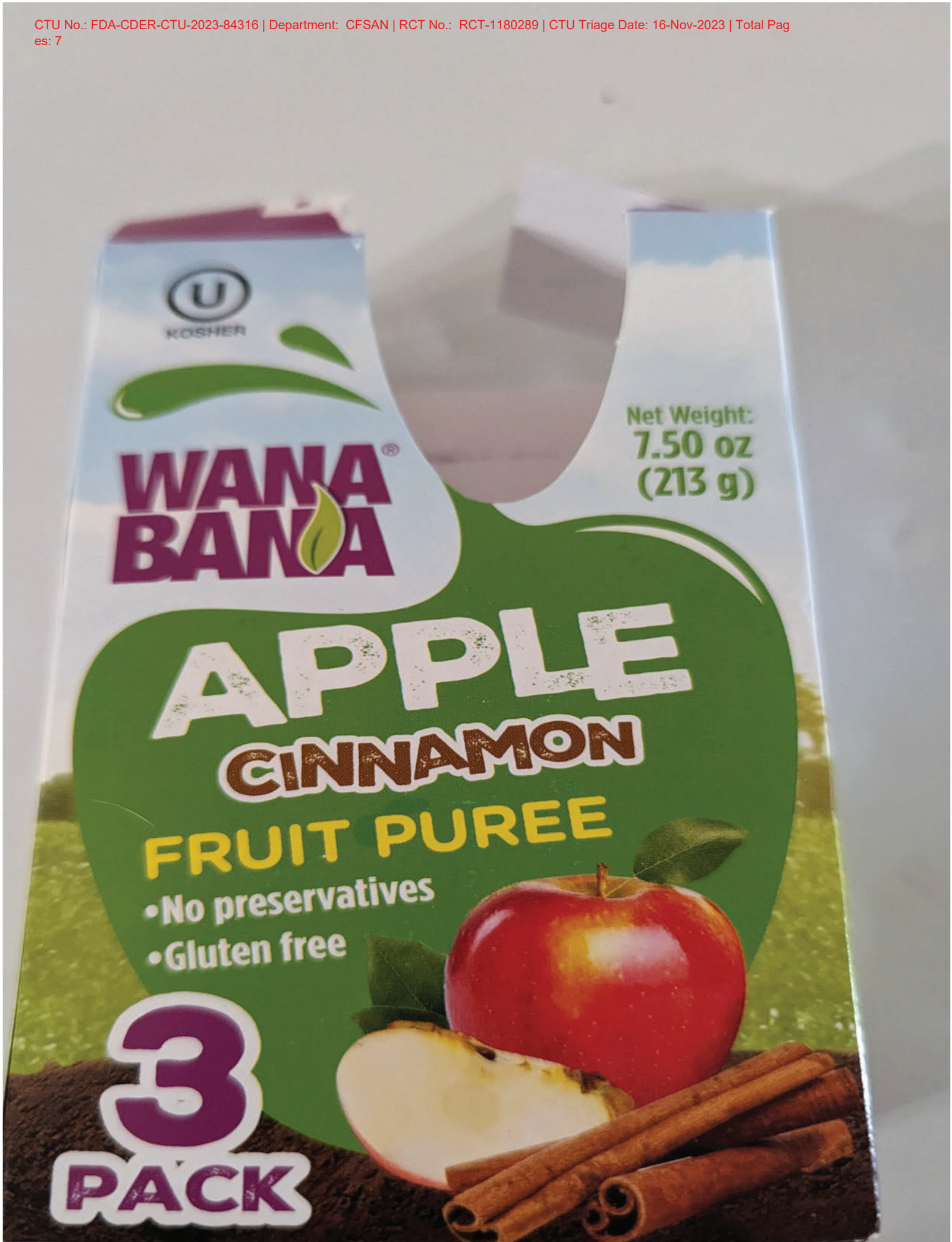
List all current prescription medications and medical devices being used.
Adderall, Vyvanse, Abilify and Guanfacine

List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

Section F - About the Person Filling Out This Form 1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b)(6)
Middle Name	
First name	(b)(6)
Number/Street	
City	
State/Province	
Country	UNITED STATES
ZIP or Postal code	(b)(6)
Telephone number	
Email address	
Fax	
Reporter Organization	

	Department		
	Reporter Speciality		
	Today's date	15-Nov-2023	
	Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No	
	If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No	



al Fat 0g	0%
tuated Fat 0g	
ans Fat 0g	0%
esterol 0mg	0%
um 0mg	4%
Carbohydrate 12g	7%
ary Fiber 2g	
l Sugars 9g	0%
cludes 0g Added Sugars	
n 0g	
D 0mcg	0%
n 4mg	0%
mg	0%
um 60mg	0%

ly Value (DV) tells you how much a nutrient in a
od contributes to a daily diet. 2,000 calories a day is
eral nutrition advice.

: Apple puree, cinnamon powder,
tric acid.

LE FOR MICROWAVE

roduced / Best by / see package

LOT: 05023:09

EXP:07–09–2024

All dates displayed in the report are in EST(GMT-05:00) time zone

Basic Details

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	15-Nov-2023	CTU Received Date	15-Nov-2023
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	☑ CDER (CDER-OSE-RSS-CTU@fda.hhs.gov) (E2B)		
Case Priority	Direct		

Contact

Case Reporter	First Name	Last Name	Email Address	Phone
☑	(b)(6)	(b)(6)	(b)(6)	(b)(6)

Section A - About the Problem

	What kind of problem was it? (Check all that apply)	☑ Were hurt or had a bad side effect (including new or worsening symptoms) ☐ Used a product incorrectly which could have or led to a problem ☑ Noticed a problem with the quality of the product ☐ Had problems after switching from one product maker to another maker
	Date the problem occurred	24-Jul-2023
	Serious	Yes
	Did any of the following happen? (Check all that apply)	☐ Hospitalization - admitted or stayed longer ☑ Required help to prevent permanent harm ☐ Disability or health problem ☐ Birth defect ☐ Life-threatening ☐ Death ☑ Other serious/important medical incident(Please Describe Below)
	Other serious/important medical incident(Please Describe Below)	

4.Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

My daughter received a blood test with results of abnormal levels of lead in her blood. She has been more irritable and cranky.

Relevant Test/Laboratory Data 1 of 1

	Test Name	LEAD	Test Date	24-Jul-2023
	Test Result	8.2	Test Unit	
	Low Test Range		High Test Range	

More Information Available?	

Additional Comments

Section B - Product Availability

Do you still have the product in case we need to evaluate it?	No
Do you have a picture of the product? (check yes if you are including a picture)	No

Section C - About the Products 1 of 1

Suspect	Yes		
Primary?	Yes		
Type	Drug/Biologic		
This report is about	Food/Medical food		
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Wana bana apple cinnamon fruit puree		
Name of the company that makes (or compounds) the product	Wana bana		
Product Type(check all that apply)	☑ Over-the-Counter ☐ Compounded by a Pharmacy or an Outsourcing Facility ☐ Generic ☐ Biosimilar		
Strength		If Other	
NDC number			
Did the problem stop after the person reduced the dose or stopped taking or using the product?	Yes		
Did the problem return if the person started taking or using the product again?	Doesn't Apply		

Drug Therapy 1 of 1

Expiration date			
Lot number			
Dosage Form			
Quantity		If Other	
Frequency		If Other	
How was it taken or used		If Other	
Date the person first started taking or using the product	07-Oct-2022		
Date the person stopped taking or using the product	15-Feb-2023		

	Date the person reduced dose of the product	
	Give best estimate of duration	
	Is therapy still on-going?	

Why was the person using the product? (such as what condition was it supposed to treat) 1 of 1

	Good pick pouch

	Returned to Manufacturer On	

Section D - About the Medical Device

	Name of medical device	
	Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

	Model Number	
	Catalog Number	
	Lot Number	
	Serial Number	
	UDDI Number	
	Expiration date	
	Was someone operating the medical device when the problem occurred?	

For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	

Section E - About the Person Who Had the Problem

	Person's Initials	(b)(6)
	Sex	Female
	Gender	Cisgender woman/girl
	Please Specify Other Gender	
	Age (specify unit of time for age)	
	Date of Birth	(b)(6)
	Weight	10.8 kg
	Ethnicity (Choose only one)	Not Hispanic/Latino
	Race (Check all that apply)	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian

	☑ White ☐ Black or African American

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

Please list all allergies (such as to drugs, foods, pollen or others)

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

List all current prescription medications and medical devices being used.

List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

Section F - About the Person Filling Out This Form 1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b)(6)
Middle Name	
First name	(b)(6)
Number/Street	
City	
State/Province	
Country	UNITED STATES
ZIP or Postal code	(b)(6)
Telephone number	
Email address	

	Fax		
	Reporter Organization		
	Department		
	Reporter Speciality		
	Today's date	15-Nov-2023	
	Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No	
	If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No	

All dates displayed in the report are in EST(GMT-05:00) time zone

Basic Details

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	15-Nov-2023	CTU Received Date	15-Nov-2023
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	☑ CDER (CDER-OSE-RSS-CTU@fda.hhs.gov) (E2B)		
Case Priority	Direct		

Contact

Case Reporter	First Name	Last Name	Email Address	Phone
☑	(b)(6)	(b)(6)	(b)(6)	(b)(6)

Section A - About the Problem

What kind of problem was it? (Check all that apply)	☑ Were hurt or had a bad side effect (including new or worsening symptoms) ☐ Used a product incorrectly which could have or led to a problem ☐ Noticed a problem with the quality of the product ☐ Had problems after switching from one product maker to another maker
Date the problem occurred	08-Aug-2023
Serious	Yes
Did any of the following happen? (Check all that apply)	☐ Hospitalization - admitted or stayed longer ☐ Required help to prevent permanent harm ☐ Disability or health problem ☐ Birth defect ☐ Life-threatening ☐ Death ☑ Other serious/important medical incident(Please Describe Below)
Other serious/important medical incident(Please Describe Below)	

4.Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

My son was approximately 15 months old when I started to feed my son the wanabana fruit puree pouches. We had the apple cinnamon, banana, pineapple and mango. I brought him to the Dr. For his 1 year wellness check up and his lead level was a 2. I recently had his led levels tested and it is at a 4.5.

Relevant Test/Laboratory Data 1 of 2

Test Name	LEAD	Test Date	11-Nov-2023
Test Result	4	Test Unit	MICROGRAMS PER DECILITRE

	Low Test Range	0.0	High Test Range	3.4
	More Information Available?			

Relevant Test/Laboratory Data 2 of 2

	Test Name	LEAD	Test Date	08-Aug-2023
	Test Result	2	Test Unit	MICROGRAMS PER DECILITRE
	Low Test Range	0.0	High Test Range	3.4
	More Information Available?			

Additional Comments

Section B - Product Availability

	Do you still have the product in case we need to evaluate it?	No
	Do you have a picture of the product? (check yes if you are including a picture)	No

Section C - About the Products 1 of 1

	Suspect	Yes		
	Primary?	Yes		
	Type	Drug/Biologic		
	This report is about	Food/Medical food		
	Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	Wanna bana fruit puree pouchedls		
	Name of the company that makes (or compounds) the product			
	Product Type(check all that apply)	☐ Over-the-Counter ☐ Compounded by a Pharmacy or an Outsourcing Facility ☐ Generic ☐ Biosimilar		
	Strength		If Other	
	NDC number			
	Did the problem stop after the person reduced the dose or stopped taking or using the product?			
	Did the problem return if the person started taking or using the product again?			

Drug Therapy 1 of 1

	Expiration date	

	Lot number				
	Dosage Form				
	Quantity		If Other		
	Frequency		If Other		
	How was it taken or used		If Other		
	Date the person first started taking or using the product	01-Feb-2023			
	Date the person stopped taking or using the product	30-Sep-2023			
	Date the person reduced dose of the product				
	Give best estimate of duration				
	Is therapy still on-going?				

Why was the person using the product? (such as what condition was it supposed to treat) 1 of 1

	Returned to Manufacturer On	

Section D - About the Medical Device

	Name of medical device	
	Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

	Model Number	
	Catalog Number	
	Lot Number	
	Serial Number	
	UDDI Number	
	Expiration date	
	Was someone operating the medical device when the problem occurred?	

For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	

Section E - About the Person Who Had the Problem

	Person's Initials	(b)(6)
	Sex	Male
	Gender	Not selected

Please Specify Other Gender	
Age (specify unit of time for age)	
Date of Birth	(b)(6)
Weight	
Ethnicity (Choose only one)	Not Hispanic/Latino
Race (Check all that apply)	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White ☑ Black or African American

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

Please list all allergies (such as to drugs, foods, pollen or others)

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

List all current prescription medications and medical devices being used.

List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

Section F - About the Person Filling Out This Form 1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b)(6)
Middle Name	
First name	(b)(6)

	Number/Street		
	City	(b)(6)	
	State/Province		
	Country	UNITED STATES	
	ZIP or Postal code	(b)(6)	
	Telephone number		
	Email address		
	Fax		
	Reporter Organization		
	Department		
	Reporter Speciality		
	Today's date	15-Nov-2023	
	Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No	
	If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No	

MedWatch 3500 Health Professional Report

The FDA Safety Information and Adverse Event Reporting Program

FDA Safety Report ID #	681167	FDA Received Date	15-Nov-2023

A. PATIENT INFORMATION		
A1. Patient Identifier:	(b)(6)	
A2. Age:	2	Year(s)
A2. Date of Birth:		
A3a. Sex: Enter the patient's sex at birth	Male	Yes
	Female	
	Undifferentiated	
	Decline to answer	
A3b. Gender: Enter the patient's current gender	Cisgender man/boy (gender corresponds with birth sex)	
	Cisgender woman/girl (gender corresponds with birth sex)	
	Transgender man/trans man/female-to-male (FTM)	
	Transgender woman/trans woman/ male-to-female (MTF)	
	Other gender category; Please specify:	
	Decline to answer	
A4. Weight:		
A5. Ethnicity:	Hispanic/Latino	
	Not Hispanic/Latino	Yes
A6. Race:	Asian	
	American Indian or Alaskan Native	
	Black or African American	
	White	Yes
	Native Hawaiian or Other Pacific Islander	

B. ADVERSE EVENT, PRODUCT PROBLEM			
B1. Type of Report:	Adverse Event		
	Product Use/Medication Error		
	Product Problem (e.g., defects/malfunctions)	Yes	
	Problem with Different Manufacturer of Same Medicine		
B2. Outcome Attributed to Adverse Event:	Death *(Date of Death)*		
	Life-threatening		
	Hospitalization (initial or prolonged)		
	Disability or Permanent Damage		
	Congenital Anomaly/Birth Defects		
	Other Serious or Important Medical Events	Yes	
	Required Intervention to Prevent Permanent Impairment/Damage		
B3. Date of Event:	25-Oct-2023		
B4. Date of this Report:	15-Nov-2023		

B5. Describe Event, Problem or Product Use/Medication Error:

Child had an elevated blood lead level of 9.1 per venous draw on 10/25/23. Mother has since called in and stated that the child had been eating the recalled WanaBana Apple Cinnamon Fruit Puree pouches which she had received from a food bank and had also bought from dollar tree. Mother estimates child was sometimes eating up to two to three packs of the fruit puree per day.

B6. Relevant Tests/Laboratory Data:	
Test 1	
Test Date:	25-Oct-2023
Test Name:	venous lead level
Test Result:	9.1
Test Unit:	UG/DL
Low Test Range:	0
High Test Range:	
Test 2	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 3	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 4	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	

B6. Relevant Tests/Laboratory Data:	
Test 5	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 6	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 7	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	
Test 8	
Test Date:	
Test Name:	
Test Result:	
Test Unit:	
Low Test Range:	
High Test Range:	

B6. Additional Comments:

Lead level should be 0. Anything 3.5 or higher is considered elevated blood lead level, anything

B7. Other Relevant History, Including Preexisting Medical Conditions:

Have not been able to rule out that the Elevated blood lead level could be environmental. Plan to recheck 3 months from test date to see if lead level decreases since child has stopped eating the applesauce.

C. PRODUCT AVAILABILITY	
C1. Product Available for Evaluation?	No
C1. Returned to Manufacturer on:	
C2. Do you have a picture of the product?	

D. SUSPECT PRODUCTS		
Product 1		
D1. This report involves:	Cosmetic	
	Dietary supplement	
	Food/medical food	Yes
	Other	
D1. Name:	WanaBana Apple Cinnamon Fruit Puree pouches	
D1. Strength:		
D1. Manufacturer/Compounder:		
D1. NDC # or Unique ID:		
D1. Lot #:		
D2. Dose or Amount:		
D2. Frequency:		
D2. Route:		
D3. Treatment Dates/Therapy Dates:	Start	Stop: Dose Reduced
	Give best estimate of duration	
	Is therapy still on-going?	
D4. Diagnosis for Use:		
D5. Product Type:	OTC (Over-the-counter)	
	Compounded	
	Generic	
	Biosimilar	
D6. Expiration Date:		
D7. Event Abated After Use Stopped or Dose Reduced?	Doesn't apply	
D8. Event Reappeared After Reintroduction?	Doesn't apply	
Product 2		
D1. This report involves:	Cosmetic	
	Dietary supplement	
	Food/medical food	
	Other	
D1. Name:		
D1. Strength:		
D1. Manufacturer/Compounder:		
D1. NDC # or Unique ID:		
D1. Lot #:		
D2. Dose or Amount:		
D2. Frequency:		
D2. Route:		
D3. Treatment Dates/Therapy Dates:	Start	Stop: Dose Reduced
	Give best estimate of duration	
	Is therapy still on-going?	
D4. Diagnosis for Use:		
D5. Product Type:	OTC (Over-the-counter)	
	Compounded	
	Generic	
	Biosimilar	
D6. Expiration Date:		
D7. Event Abated After Use Stopped or Dose Reduced?		
D8. Event Reappeared After Reintroduction?		

E. SUSPECT MEDICAL DEVICE			
E1. Brand Name:	WanaBana Apple Cinnamon Fruit Puree pouches		
E2a. Common Device Name:			
E2b. Procode:			
E3. Manufacturer Name, City and State:			
E4. Model #:			
E4. Catalog #:			
E4. Serial #:			
E4. Lot #:			
E4. Expiration Date:			
E4. Unique Device Identifier (UDI) #:			
E5. Operator of Device:	Health Professional		
	Patient/Consumer		
	Other		
E6a. If Implanted, Give Date:			
E6b. If Explanted, Give Date:			
E7a. Is this a single-use device that was reprocessed and reused on a patient?			
E7b. If Yes to Item 7a, Enter Name and Address of Reprocessor:			
E8. Was this device serviced by a third party servicer?			

F. OTHER (CONCOMITANT) MEDICAL PRODUCTS

Product Name	Therapy Start Date	Therapy End Date
1. WanaBana Apple Cinnamon Fruit Puree pouches		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		

G. REPORTER		
G1. Name and Address	Last Name	(b)(6)
	First Name	
	Address	
	City	(b)(6)
	State/Province/Region	
	ZIP/Postal Code	
	Country	US
	Phone #:	(b)(6)
	Email:	
G2. Health Professional?	Yes	
G3. Occupation:	Nurse	
G4. Also Reported To:	Manufacturer/Compounder	
	User Facility	
	Distributer/Importer	
G5. If you do NOT want your identity disclosed to the manufacturer, place an "X" in this box (Confidentiality Requested):	No	

All dates displayed in the report are in EST(GMT-05:00) time zone

Basic Details

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	16-Nov-2023	CTU Received Date	16-Nov-2023
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	☑		
Case Priority	Direct		

Contact

Case Reporter	First Name	Last Name	Email Address	Phone
☑	(b)(6)	(b)(6)	(b)(6)	

Section A - About the Problem

What kind of problem was it? (Check all that apply)	☑ Were hurt or had a bad side effect (including new or worsening symptoms) ☐ Used a product incorrectly which could have or led to a problem ☐ Noticed a problem with the quality of the product ☐ Had problems after switching from one product maker to another maker
Date the problem occurred	
Serious	No
Did any of the following happen? (Check all that apply)	☐ Hospitalization - admitted or stayed longer ☐ Required help to prevent permanent harm ☐ Disability or health problem ☐ Birth defect ☐ Life-threatening ☐ Death ☐ Other serious/important medical incident(Please Describe Below)

4.Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

My son has been consuming WanaBana Cinnamon Fruit Puree Pouches over the last several months. I heard about the recall and called his doctor, who had him go for blood work. The results show an elevated level of lead in his blood.

Relevant Test/Laboratory Data 1 of 1

Test Name	LEAD, BLOOD (VENOUS) ARUP	Test Date	06-Nov-2023	
Test Result	15.5	Test Unit	MICROGRAMS PER DECILITRE	
Low Test Range		High Test Range		

More Information Available?	

Additional Comments

Section B - Product Availability

Do you still have the product in case we need to evaluate it?	No
Do you have a picture of the product? (check yes if you are including a picture)	No

Section C - About the Products 1 of 1

Suspect	Yes		
Primary?	Yes		
Type	Drug/Biologic		
This report is about	Food/Medical food		
Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	WanaBana Apple Cinnamon Fruit Puree		
Name of the company that makes (or compounds) the product	Wanabana LLC		
Product Type(check all that apply)	☐ Over-the-Counter ☐ Compounded by a Pharmacy or an Outsourcing Facility ☐ Generic ☐ Biosimilar		
Strength		If Other	
NDC number			
Did the problem stop after the person reduced the dose or stopped taking or using the product?			
Did the problem return if the person started taking or using the product again?	Doesn't Apply		

Drug Therapy 1 of 1

Expiration date			
Lot number			
Dosage Form			
Quantity		If Other	
Frequency		If Other	
How was it taken or used	Oral	If Other	
Date the person first started taking or using the product	01-Jul-2023		
Date the person stopped taking or using the product	28-Oct-2023		

	Date the person reduced dose of the product	28-Oct-2023
	Give best estimate of duration	
	Is therapy still on-going?	

Why was the person using the product? (such as what condition was it supposed to treat) 1 of 1

	Returned to Manufacturer On	

Section D - About the Medical Device

	Name of medical device	
	Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

	Model Number	
	Catalog Number	
	Lot Number	
	Serial Number	
	UDDI Number	
	Expiration date	
	Was someone operating the medical device when the problem occurred?	

For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	

Section E - About the Person Who Had the Problem

	Person's Initials	(b)(6)
	Sex	Male
	Gender	Cisgender man/boy
	Please Specify Other Gender	
	Age (specify unit of time for age)	4.5 Year(s)
	Date of Birth	
	Weight	17.55 kg
	Ethnicity (Choose only one)	Not Hispanic/Latino
	Race (Check all that apply)	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian

☑ White ☐ Black or African American	

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

Please list all allergies (such as to drugs, foods, pollen or others)

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

List all current prescription medications and medical devices being used.

List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

Section F - About the Person Filling Out This Form 1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b)(6)
Middle Name	
First name	(b)(6)
Number/Street	
City	
State/Province	(b)(6)
Country	UNITED STATES
ZIP or Postal code	
Telephone number	
Email address	(b)(6)

	Fax		
	Reporter Organization		
	Department		
	Reporter Speciality		
	Today's date	16-Nov-2023	
	Did you report this problem to the company that makes the product (the manufacturer/compounder)?	No	
	If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No	

All dates displayed in the report are in EST(GMT-05:00) time zone

Basic Details

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	16-Nov-2023	CTU Received Date	16-Nov-2023
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	☑ CDER (CDER-OSE-RSS-CTU@fda.hhs.gov) (E2B)		
Case Priority	Direct		

Contact

Case Reporter	First Name	Last Name	Email Address	Phone
☑	(b)(6)	(b)(6)	(b)(6)	(b)(6)

Section A - About the Problem

	What kind of problem was it? (Check all that apply)	☑ Were hurt or had a bad side effect (including new or worsening symptoms) ☐ Used a product incorrectly which could have or led to a problem ☐ Noticed a problem with the quality of the product ☐ Had problems after switching from one product maker to another maker
	Date the problem occurred	20-Oct-2023
	Serious	Yes
	Did any of the following happen? (Check all that apply)	☐ Hospitalization - admitted or stayed longer ☐ Required help to prevent permanent harm ☐ Disability or health problem ☐ Birth defect ☐ Life-threatening ☐ Death ☑ Other serious/important medical incident(Please Describe Below)
	Other serious/important medical incident(Please Describe Below)	

4.Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

On October 19th 2023 my mother (grandmother of those affected) purchased WanaBana Cinnamon fruit puree at a Dollar Tree in (b)(6). The pouches purchased were from LOT 02023:18 15:13, which are listed on the recall. My sons ages 2.5 years and 15 months both ingested only 2 pouches each of the fruit puree pouches between 10/20/2023 and 10/24/2023. Both of my children have previously been tested for lead at their regular check ups with undetectable results. After seeing the recall of these fruit puree pouches I immediately had them tested for lead at their pediatrician. Both of their test results came back with elevated levels of lead in their blood. Our pediatrician has referred us to a specialist at a lead clinic with (b)(6). We are also seeking legal counsel to review and develop a path forward if they are to have any medical problems from this in the future.

Relevant Test/Laboratory Data 1 of 1

	Test Name	LEAD	Test Date	31-Oct-2023

	Test Result	4	Test Unit	MICROGRAMS PER DECILITRE	
	Low Test Range	0	High Test Range		
	More Information Available?				

Additional Comments

Section B - Product Availability

	Do you still have the product in case we need to evaluate it?	Yes
	Do you have a picture of the product? (check yes if you are including a picture)	No

Section C - About the Products 1 of 1

	Suspect	Yes			
	Primary?	Yes			
	Type	Drug/Biologic			
	This report is about	Food/Medical food			
	Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	WanaBana Apple Cinnamon fruit puree			
	Name of the company that makes (or compounds) the product	WanaBana			
	Product Type(check all that apply)	☐ Over-the-Counter ☐ Compounded by a Pharmacy or an Outsourcing Facility ☐ Generic ☐ Biosimilar			
	Strength		If Other		
	NDC number				
	Did the problem stop after the person reduced the dose or stopped taking or using the product?				
	Did the problem return if the person started taking or using the product again?	Doesn't Apply			

Drug Therapy 1 of 1

	Expiration date	18-Apr-2024			
	Lot number	02023:18 15:13			
	Dosage Form				
	Quantity	Other	If Other	2 Pouches	
	Frequency		If Other		
	How was it taken or used	Oral	If Other		

	Date the person first started taking or using the product	20-Oct-2023	
	Date the person stopped taking or using the product	24-Oct-2023	
	Date the person reduced dose of the product		
	Give best estimate of duration		
	Is therapy still on-going?		

Why was the person using the product? (such as what condition was it supposed to treat) 1 of 1

	Returned to Manufacturer On		

Section D - About the Medical Device

	Name of medical device		
	Name of the company that makes the medical device		

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

	Model Number		
	Catalog Number		
	Lot Number		
	Serial Number		
	UDDI Number		
	Expiration date		
	Was someone operating the medical device when the problem occurred?		

For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	

Section E - About the Person Who Had the Problem

	Person's Initials	(b)(6)	
	Sex	Male	
	Gender	Cisgender man/boy	
	Please Specify Other Gender		
	Age (specify unit of time for age)		
	Date of Birth	(b)(6)	
	Weight	12.6 kg	
	Ethnicity (Choose only one)	Not Hispanic/Latino	

Race (Check all that apply)	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☑ White ☐ Black or African American

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

Please list all allergies (such as to drugs, foods, pollen or others)

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

List all current prescription medications and medical devices being used.

List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

Probiotic, Vitamin C, Childrens multivitamin

Section F - About the Person Filling Out This Form 1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b)(6)
Middle Name	
First name	(b)(6)
Number/Street	
City	
State/Province	
Country	UNITED STATES
ZIP or Postal code	(b)(6)

	Telephone number	(b)(6)	
	Email address		
	Fax		
	Reporter Organization		
	Department		
	Reporter Speciality		
	Today's date	16-Nov-2023	
	Did you report this problem to the company that makes the product (the manufacturer/compounder)?	Yes	
	If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No	

All dates displayed in the report are in EST(GMT-05:00) time zone

Basic Details

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500B
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	16-Nov-2023	CTU Received Date	16-Nov-2023
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	☑ CDER (CDER-OSE-RSS-CTU@fda.hhs.gov) (E2B)		
Case Priority	Direct		

Contact

Case Reporter	First Name	Last Name	Email Address	Phone
☑	(b)(6)	(b)(6)	(b)(6)	(b)(6)

Section A - About the Problem

	What kind of problem was it? (Check all that apply)	☑ Were hurt or had a bad side effect (including new or worsening symptoms) ☐ Used a product incorrectly which could have or led to a problem ☐ Noticed a problem with the quality of the product ☐ Had problems after switching from one product maker to another maker
	Date the problem occurred	20-Oct-2023
	Serious	Yes
	Did any of the following happen? (Check all that apply)	☐ Hospitalization - admitted or stayed longer ☐ Required help to prevent permanent harm ☐ Disability or health problem ☐ Birth defect ☐ Life-threatening ☐ Death ☑ Other serious/important medical incident(Please Describe Below)
	Other serious/important medical incident(Please Describe Below)	

4.Tell us what happened and how it happened (Include as many details as possible FDA may reach out to you for any additional documents if necessary)

On October 19th 2023 my mother (grandmother of those affected) purchased WanaBana Cinnamon fruit puree at a Dollar Tree in (b)(6). The pouches purchased were from LOT 02023:18 15:13, which are listed on the recall. My sons ages 2.5 years and 15 months both ingested only 2 pouches each of the fruit puree pouches between 10/20/2023 and 10/24/2023. Both of my children have previously been tested for lead at their regular check ups with undetectable results. After seeing the recall of these fruit puree pouches I immediately had them tested for lead at their pediatrician. Both of their test results came back with elevated levels of lead in their blood. Our pediatrician has referred us to a specialist at a lead clinic with (b)(6). We are also seeking legal counsel to review and develop a path forward if they are to have any medical problems from this in the future.

Relevant Test/Laboratory Data 1 of 1

	Test Name	LEAD	Test Date	31-Oct-2023

	Test Result	5	Test Unit	MICROGRAMS PER DECILITRE	
	Low Test Range	0	High Test Range		
	More Information Available?				

Additional Comments

Section B - Product Availability

	Do you still have the product in case we need to evaluate it?	Yes
	Do you have a picture of the product? (check yes if you are including a picture)	No

Section C - About the Products 1 of 1

	Suspect	Yes		
	Primary?	Yes		
	Type	Drug/Biologic		
	This report is about	Food/Medical food		
	Name of the product as it appears on the box, bottle, or package (Include as many names as you see)	WanaBana Apple Cinnamon fruit puree		
	Name of the company that makes (or compounds) the product	WanaBana		
	Product Type(check all that apply)	☐ Over-the-Counter ☐ Compounded by a Pharmacy or an Outsourcing Facility ☐ Generic ☐ Biosimilar		
	Strength		If Other	
	NDC number			
	Did the problem stop after the person reduced the dose or stopped taking or using the product?			
	Did the problem return if the person started taking or using the product again?	Doesn't Apply		

Drug Therapy 1 of 1

	Expiration date	18-Apr-2024		
	Lot number	02023:18 15:13		
	Dosage Form			
	Quantity	Other	If Other	2 Pouches
	Frequency		If Other	
	How was it taken or used	Oral	If Other	

	Date the person first started taking or using the product	20-Oct-2023	
	Date the person stopped taking or using the product	24-Oct-2023	
	Date the person reduced dose of the product		
	Give best estimate of duration		
	Is therapy still on-going?	Yes	

Why was the person using the product? (such as what condition was it supposed to treat) 1 of 1

	Returned to Manufacturer On	

Section D - About the Medical Device

	Name of medical device	
	Name of the company that makes the medical device	

Other identifying information (The model, catalog, lot, serial, or UDI number, and the expiration date, if you can locate them)

	Model Number	
	Catalog Number	
	Lot Number	
	Serial Number	
	UDDI Number	
	Expiration date	
	Was someone operating the medical device when the problem occurred?	

For implanted medical devices ONLY (such as pacemakers, breast implants, etc.)

Date the implant was put in		Date the implant was taken out (If relevant)	

Section E - About the Person Who Had the Problem

	Person's Initials	(b)(6)
	Sex	Male
	Gender	Cisgender man/boy
	Please Specify Other Gender	
	Age (specify unit of time for age)	
	Date of Birth	(b)(6)
	Weight	15.75 kg
	Ethnicity (Choose only one)	Not Hispanic/Latino

Race (Check all that apply)	☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☑ White ☐ Black or African American

List known medical conditions (Such as diabetes, high blood pressure, cancer, heart disease, or others)

Please list all allergies (such as to drugs, foods, pollen or others)

List any other important information about the person (such as smoking, pregnancy, alcohol use, etc.)

List all current prescription medications and medical devices being used.

List all over-the-counter medications and any vitamins, minerals, supplements, and herbal remedies being used.

Probiotic, Vitamin C, Childrens multivitamin

Section F - About the Person Filling Out This Form 1 of 1

Primary?	Yes
Reporter is Patient?	
Title	
Last name	(b)(6)
Middle Name	
First name	(b)(6)
Number/Street	
City	
State/Province	
Country	UNITED STATES
ZIP or Postal code	(b)(6)

	Telephone number	(b)(6)	
	Email address		
	Fax		
	Reporter Organization		
	Department		
	Reporter Speciality		
	Today's date	16-Nov-2023	
	Did you report this problem to the company that makes the product (the manufacturer/compounder)?	Yes	
	If you do NOT want your identity disclosed to the manufacturer, please mark this box (Confidentiality Requested):	No	

All dates displayed in the report are in EST(GMT-05:00) time zone

Basic Details

Company Unit	CDER-CTU	Originating Account	FAERS
Source Medium	MWO (Drug)	Source Form Type	E2B XML 3500
Priority	Routine		
Override Auto Calculation Rule	No		
FDA Received Date	17-Nov-2023	CTU Received Date	17-Nov-2023
CTU Triage Date		CTU Data Entry Date	
Report Type	Spontaneous	Report Classification	Drug
Assign To	User		
User/Group			
Forward to Department	☑ CDER (CDER-OSE-RSS-CTU@fda.hhs.gov) (E2B)		
Case Priority	Direct		

Contact

Case Reporter	First Name	Last Name	Email Address	Phone
☑	(b)(6)	(b)(6)	(b)(6)	(b)(6)

A. PATIENT INFORMATION

	Patient Identifier (In Confidence)	(b)(6)
	Age	13 Month(s)
	Date of Birth	
	Sex	Male
	Gender	Not selected
	Please Specify Other Gender	
	Weight	
	Ethnicity (Check single best answer)	Not Hispanic/Latino
	Race (Check all that apply)	☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American ☑ White ☐ Native Hawaiian or Other Pacific Islander

B. ADVERSE EVENT, PRODUCT PROBLEM

	Type of Report (check all that apply)	☐ Adverse Event ☐ Product Use/Medication Error ☑ Product Problem (e.g., defects/malfunctions) ☐ Problem with Different Manufacturer of Same Medicine
	Serious	Yes
	Outcome Attributed to Adverse Event (Check all that apply)	☐ Death ☐ Life Threatening ☐ Hospitalization (initial or prolonged) ☑ Other Serious or Important Medical Events ☐ Disability or Permanent Damage

	☐ Congenital Anomaly/Birth Defects ☐ Required Intervention to Prevent Permanent Impairment/Damage
Date of Death	
Date of Event	10-Nov-2023
Date of this Report	17-Nov-2023

Describe Event, Problem or Product Use Error

Describe Event, Problem, or Product Use Error: Patient consumed a product (Wana Bana) that was recalled for elevated levels of lead. Once patients mother found out about the recall and they had some of the recalled product lot number 01023:23 she had scheduled an appointment to get lead levels tested. The patients lead levels were elevated at 6.4 ug/dl. Patient will be getting re-tested in 2-4 weeks to ensure that the levels are back down.

Relevant Test/Laboratory Data 1 of 1

Test Name	LEAD BLOOD (PEDIATRIC) VENOUS	Test Date	10-Nov-2023
Test Result	6.4	Test Unit	MICROGRAMS PER DECILITRE
Low Test Range	0.0	High Test Range	3.4
More Information Available?			

Additional Comments

Other Relevant History, Including Preexisting Medical Conditions

C. PRODUCT AVAILABILITY

Product Available for Evaluation? (Do not send product to FDA)	Yes
Returned to Manufacturer on	
Do you have a picture of the product? (check yes if you are including a picture)	Yes

D. PRODUCT(S) 1 of 1

Suspect	Yes
Primary?	Yes
Type	Drug/Biologic
This report involves:	Food/Medical food

Name,Strength,Manufacturer/Compounder (from product label)

Product Name	Wana Bana Apple Cinnamon Fruit Puree Pouches		
Strength		If Other	
Manufacturer/Compounder	Wana Bana-Austrofood		

	NDC# or Unique ID	
	Product Type(check all that apply)	☐ OTC ☐ Compounded ☐ Generic ☐ Biosimilar
	Event Abated After Use Stopped or Dose Reduced?	
	Event Reappeared after Reintroduction ?	

Drug Therapy 1 of 1

	Dose or Amount		If Other		
	Frequency	Other	If Other	Whenever	
	Route		If Other		
	Dosage Form				
	Start				
	Stop				
	Dose Reduced				
	Therapy Duration		If Other		
	Is therapy still on-going?	No			
	Lot Number	01023:23			
	Expiration Date	23-Mar-2024			

Diagnosis for Use (indication) 1 of 1

	Was a food product (snack) So given when patient wanted it.

E. SUSPECT MEDICAL DEVICE

	Brand Name	
	Common Device Name	
	Procode	
	Manufacturer Name	
	City	
	State	
	Model #	
	Lot #	
	Catalog #	
	Expiration Date	
	Serial #	
	Unique Identifier (UDI)#	
	Operator of Device	☐ Health Professional ☐ Patient/Consumer ☐ Other
	Other	
	If Implanted, Give Date	

	If Explanted, Give Date	
	Is this a single-use device that was reprocessed and reused on a patient?	
	If Yes for the above field, Enter Name and Address of Reprocessor	
	Was this device serviced by a third party?	

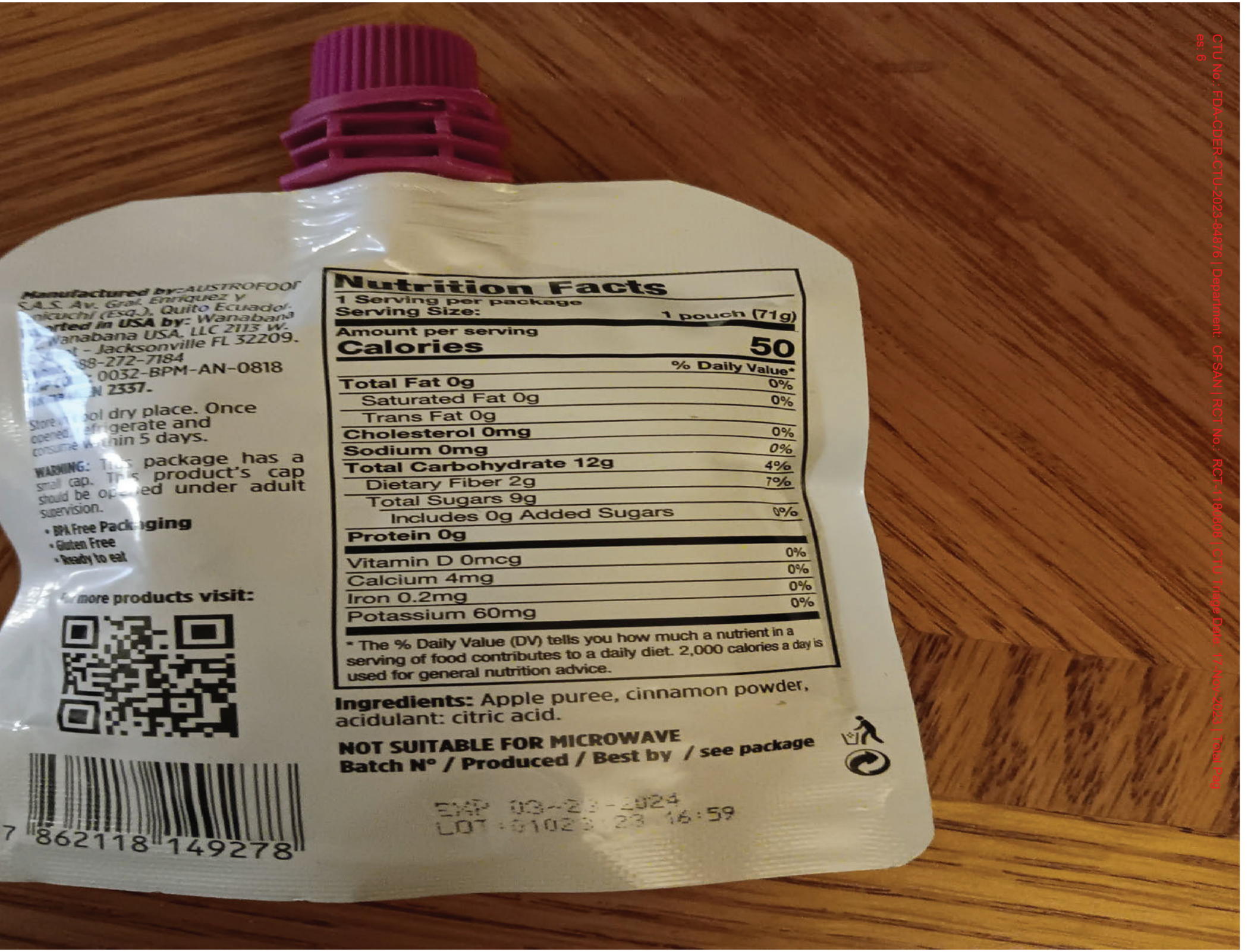
F. OTHER (CONCOMITANT) MEDICAL PRODUCTS

CONCOMITANT MEDICAL PRODUCT DESCRIPTION

G. REPORTER

1 of 1

	Primary?	Yes		
	Reporter is Patient?			
	Title			
	Last Name	(b)(6)		
	Middle Name			
	First Name	(b)(6)		
	Address			
	City			
	State/Province/Region			
	Country	UNITED STATES	If Other	
	ZIP/Postal Code	(b)(6)		
	Phone			
	Email			
	Fax			
	Reporter Organization			
	Department			
	Reporter Speciality			
	Health Professional?	Yes		
	Occupation	Other Health Professional	If Other	
	Also Reported to	☐ Manufacturer/Compounder ☐ User Facility ☐ Distributor/Importer		
	If you do NOT want your identity disclosed to the manufacturer	No		



Manufactured by: AUSTROFOOD S.A.S. Av. Gral. Enriquez y Unicuchi (Esq.), Quito Ecuador.
Imported in USA by: Wanabana USA, LLC 2113 W. 6th St - Jacksonville FL 32209.
888-272-7184
0032-BPM-AN-0818
AN 2337.

Store in cool dry place. Once opened, refrigerate and consume within 5 days.

WARNING: This package has a small cap. This product's cap should be opened under adult supervision.

- BPA Free Packaging
- Gluten Free
- Ready to eat

For more products visit:

7 862118 149278

Nutrition Facts

1 Serving per package
Serving Size: 1 pouch (71g)

Amount per serving
Calories 50

	% Daily Value*
Total Fat 0g	0%
Saturated Fat 0g	0%
Trans Fat 0g	
Cholesterol 0mg	0%
Sodium 0mg	0%
Total Carbohydrate 12g	4%
Dietary Fiber 2g	7%
Total Sugars 9g	
Includes 0g Added Sugars	0%
Protein 0g	
Vitamin D 0mcg	0%
Calcium 4mg	0%
Iron 0.2mg	0%
Potassium 60mg	0%

* The % Daily Value (DV) tells you how much a nutrient in a serving of food contributes to a daily diet. 2,000 calories a day is used for general nutrition advice.

Ingredients: Apple puree, cinnamon powder, acidulant: citric acid.

NOT SUITABLE FOR MICROWAVE
Batch N° / Produced / Best by / see package

EXP 03-23-2024
LOT 01023 23 16:59