**Child and Adult Care Food Program**

**ENROLLMENT FORM**

(to be completed only by the parent or guardian)

For enrollment in the CACFP of:

DAY CARE PROVIDER

I wish to enroll my child/children whose names and enrollment information are given below, in the CACFP, which reimburses day care providers for serving nutritious, well-balanced meals to day care children.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Child’s Name** | **Birthdate** | **Normal Hours**  **in Care** | | **Meals Normally Received**  **(Mark X)** | | | | | |
| From | To | Break-fast | A.M. Snack | Lunch | P.M. Snack | Supper | Evening Snack |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

Circle normal days in care: Mon Tues Wed Thurs Fri Sat Sun

Does this child have a disability, food allergies or other special dietary requirements?  Yes  No (If yes, check with your provider about the information to attach to this form.)

Is this child under 12 months old and on special formula because of doctor’s orders?  Yes  No (We must have a signed

doctor’s form on file.)

**If this child is under 12 months old, a formula option must be indicated below.**

**Be sure to enter the name of the formula being offered.**

The options for my infant have been explained. I have indicated my choice(s) below:

     1) I will accept the formula my provider offers, which is:

     2) I will supply my own breast milk.

     3) I will supply the formula of my choice which is:       and allow the provider to supply the foods.

     4) I will supply the formula which is       and foods.

     5) I will supply the specialized formula prescribed by my doctor, which is       . (We must have a signed doctor’s form on file.)

I understand my child/children will receive meals at no extra charge to me when in care during any of the scheduled meal services. I understand that the day care home cannot and will not discriminate for reasons of race, color, national origin, sex, age, or disability. I understand that I may be contacted by the sponsor regarding meals claimed by the provider for my child. If I need to be contacted by phone to update and/or verify this information at any time, I would prefer being called at:  Work  Home

|  |  |  |
| --- | --- | --- |
| Parent’s Name (print) |  | Home Telephone Number  (      ) |
| Parent’s Signature Date |  | Work Telephone Number  (      ) |
| Address |  | Start Date |
|  |  |

**Ethnic and Racial Categories (You are not required to answer this.)**

Check the ethnic and racial category of your child. We need this information to be sure that everyone receives benefits on a fair basis.

**Ethnicity: Race:**

Hispanic or Latino  White  American Indian or Alaskan Native

Not Hispanic or Latino  Black or African American  Native Hawaiian or Other Pacific Islander

Asian  Multi-Racial

**Confidentiality**

The information you provide will be treated confidentially and will be used only for eligibility determination and verification of data for CACFP purposes.