



Enrollment Form

Child and Adult Care Food Program



Child's Name _____
Address _____

Birth Date _____
Is this child **related** to the provider?
No Yes If **yes**, how? _____

Normal Hours of Care (write in times) _____

Enrollment Date: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start:							
End:							

Does parent work a varied schedule? Yes No If **yes**, please explain:

Meals to be served by the provider (Please circle)

Breakfast AM Snack Lunch PM Snack Supper Evening Snack

Is this child of school age? Yes No
If **yes**, will additional meals be provided when school is not in session? Yes No
If **yes**, please Circle the meal(s): Breakfast AM Snack Lunch PM Snack Supper Evening Snack

If your child is an infant (0 to 12 months of age): (please check one)

- I will provide the formula for my child Name of formula* _____
- I will supply breast milk for my child Formula will be supplied by my child care provider

An Infant Meal Waiver is required unless the provider supplies formula and solid infant foods.

Parental Contacts: This child care facility participates in the CACFP. In order to receive funds, representatives of the sponsoring organization or the State Agency may contact you to verify your child's participation. Please indicate what time and method of contact you prefer:

Letter _____ Phone (Home) _____ Phone (Work) _____ Time of day _____

Parent/Guardian's Name _____
Address _____
City _____ State _____ Zip _____
Home Phone Number (_____) _____
Work Phone Number (_____) _____

Provider's Name _____
Address _____
City _____

Parent/Guardian Signature _____ Date _____

Provider Signature _____ Date _____

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Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; (800) 845-6136 (Spanish).
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Date Withdrawn _____

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