Child Enrollment Form

Child & Adult Care Food Program

**Provider Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dear Parent/Guardian:

Your **Family Day Care Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ participates in the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) administered by the Massachusetts Department of Elementary and Secondary Education.

Meals served must meet nutrition requirements established by USDA’s Child & Adult Care Food Program. In order to participate, your provider has agreed to follow the USDA guidelines. A medical statement from your doctor is necessary if your child cannot eat foods required by the CACFP.

In an effort to assess that these requirements are being met, the USDA and CACFP requires providers to annually collect the enrollment information listed below.

**Please complete the form and return it to your Family Day Care Provider. Part 1 and Part 3 need to be completed by all families or guardians. Part 2 is to be completed ONLY if enrolling an infant child (under the age of 12 months).**

**PART 1: CHILD ENROLLMENT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s First Name  |  Last Name | Child’s Date of Birth & Age | Beginning Date of Child Care |
|  |   |  |  |
| Assigned # \_\_\_\_\_\_\_\_**Times Child Normally Attends** For example 7:30 AM – 5 PM **School Age Child**Time Child Attends SchoolChild attends full day during school closures:Is this the Day Care Providers Own Child YES NO  | Hours from:\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_School Hours from:\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ No | Check the days your child normally attends | 🞎 Sunday 🞎 Monday🞎 Tuesday🞎 Wednesday🞎 Thursday🞎 Friday🞎 Saturday | Check the meals you request that your child receives while in care | 🞎 Breakfast 🞎 AM Snack🞎 Lunch🞎 PM Snack🞎 Supper🞎 Evening Snack |

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s First Name  |  Last Name | Child’s Date of Birth & Age | Beginning Date of Child Care |
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|  |
| --- |
| If there are other children in care, please complete additional forms as needed. |

**FOR SPONSOR OFFICE USE ONLY**

Effective Date of this Enrollment Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fiscal Year 2017/2018

The effective date can be made retroactive back to the first day the child participates In the CACFP as long as it occurs in the same month this form is received.

**PART 2: INFANT MEAL NOTIFICATION (Birth through 11 months)**

Nutritious meals meeting the United States Department of Agriculture guidelines are served to all children enrolled in this program, including children under the age of 12 months. The child care center must meet the meal component requirements based on age and development outlined in the Infant Meal Pattern.

 I understand that this Family Day Care Provider will serve an iron fortified formula \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to my infant while in care. (Name of Iron Fortified Infant Formula)

 **To help provide the best nutritional care for your infant, please complete the following information.**

## IF YOU *FORMULA-FEED* YOUR INFANT, PLEASE CHECK ONE OPTION

 I prefer to have the Day Care Provider supply the formula offered. **OR** I will supply formula for my infant child.

## IF YOU *BREAST-FEED* YOUR INFANT, PLEASE CHECK

 I will supply expressed (pumped) breast milk for my infant child.

*I understand that this Family Day Care Provider will supply infant cereal and infants foods for infants 6 months and older as they are developmentally ready according to the CACFP requirements.*

 II prefer to have the Day Care Provider supply infant cereal and infant foods. **OR**  I will supply infant cereal and infant foods for my infant child

**PART 3: PARENT OR GUARDIAN ACCEPTANCE AND SIGNATURE**

I have read this child enrollment form and request that my child receive the above Child and Adult Care Food Program benefits. I have received a copy of this completed form.

|  |  |
| --- | --- |
|  Parent’s Signature | Date Signed (form must be completed annually) |
| Parent’s Name: |  | Home Phone: |  |
|  | Please Print |  |  |
| Mailing Address: |  | Work Phone: |  |
| City, State, Zip: |  | Cell Phone:  |  |

CIVIL RIGHTS: This information is voluntary and will not affect your children’s eligibility. Please indicate the ethnic and racial identity of your children by checking a box in each of the categories. This information is being collected to assure that everyone receives CACFP benefits on a fair basis.
1. **Ethnic Identity** □ HISPANIC OR LATINO □ NOT HISPANIC OR LATINO.
2. **Racial Identity** □ AMERICAN INDIAN OR ALASKA NATIVE □ ASIAN □ BLACK OR AFRICAN AMERICAN

 □ NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER □ WHITE.

**For questions please contact: Your Sponsor, Contact Name, Address, and Telephone Number**

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This institution is an equal opportunity provider.