Please Note any missing information Enrollment WILL be returned

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 School Child attends full day during school closures Is this the Day Care Providers Own 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

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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 2018/2019

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 provider must meet the meal component requirements based on age and developmental readiness as outlined in the Infant Meal Pattern. **Parents/Guardians may supply not more than one required component per meal in the meal pattern (including breast milk or formula) in order for the meal to be reimbursable in CACFP.**

I understand that this Family Day Care Provider has available the iron fortified formula _____ for 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 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 and/or breastfeed at the center.

☐ I have elected to have the provider supply the formula and I wish to provide one food item. I will provide the following one creditable food item:

_____

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

Jean Bianchi, Nutrition Director Clarendon Early Education Services, Inc. 360 Merrimack St. Building 5 * Suite 210 Lawrence MA 01843 781-275-2720 Ext. 112 jbianchi@clarendonees.org

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Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.