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 is school   * **Own child**   **✓ Box □ Schedule Varies** | | Hours from:  \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ | | 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 | | |
|  |  | | |  | | |  | | |
| Assigned #\_\_\_\_\_  Times Child Normally Attends  For example 7:30 AM – 5 PM  School Age Child – times in school   * **Own Child**   **✓ Box □ Schedule Varies** | | | Hours from:  \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_ | 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 | | |
|  |  | | |  | | |  | | |
| Assigned# \_\_\_\_\_\_  Times Child Normally Attends  For example 7:30 AM – 5 PM  School Age Child – Time in school   * **Own Child**   **✓ Box □ Schedule Varies** | | | Hours from:  \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_ | 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 |

|  |
| --- |
| 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 2024/2025**

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 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.**

## PLEASE CHECK ONE OPTION (Breast Milk / Formula):

I will supply expressed (pumped) breast milk for my infant child and/or breast feed at day care home. **OR**  I will supply formula for my infant child.

I prefer to have the provider supply the formula offered.

## PLEASE CHECK ONE OPTION (Food Items):

## I will supply all food items for my infant’s meals. I decline food items provided by the provider/center.

I have elected to have the provider/center supply the formula and I wish to provide one food item. I will provide the following one creditable food item: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would like provider/center to provide all food items for my infant’s meals.

**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.

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This institution is an equal opportunity provider.