Where Healthy Eating Becomes a Habit

Child & Adult Care Food Program

Enrollment Form
Child and Adult Care Food Program

CHILD CARE CONSULTANTS

Child's Name_____ **Birth Date**_____

Address_____

_____

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_____

Name of Parent/Guardian _____ Provider's Name_____

Address _____ Address_____

City_____ State____ Zip_____ City_____

Home Phone Number (_____) _____

Work Phone Number (_____) _____

_____ _____

Parent/Guardian Signature Date Provider Signature Date

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Date Withdrawn _____

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