FISCAL YEAR: _____

SPONSOR NAME: _____ **PHONE:** _____

ADDRESS: _____

CHILD REGISTRATION FORM

SITE NAME_____ADDRESS_____

Dear Parent or Legal Guardian:

The day care home provider listed above participates in the Child & Adult Care Food Program (CACFP) , a nutrition program funded by the United States Department of Agriculture (USDA) and sponsored by _____. The purpose of this program is to promote good eating habits among children. Your provider receives reimbursement for serving nutritious meals to children in her/his care. **All food served to participating children must be supplied by the day care home provider at no additional cost to you the parent/guardian.** As a parent/guardian, you are required to complete this registration form. The information contained in this form will be used by the sponsoring organization CHILD to determine the reimbursement your provider will receive for the meals served to your child(ren).

CHILD INFORMATION

Child's First then Last Name	Age	Date of Birth	Days Normally in Care / Meals* Normally Received While in Care (check all that apply): *B = Breakfast I A = AM Snack I L = Lunch I P = PM Snack I S = Supper I E = Evening Snack						
			Mon ☐B ☐A ☐L ☐P ☐S ☐E	Tues ☐B ☐A ☐L ☐P ☐S ☐E	Weds ☐B ☐A ☐L ☐P ☐S ☐E	Thurs ☐B ☐A ☐L ☐P ☐S ☐E	Fri ☐B ☐A ☐L ☐P ☐S ☐E	Sat ☐B ☐A ☐L ☐P ☐S ☐E	Sun ☐B ☐A ☐L ☐P ☐S ☐E
List arrival and departure time for daycare Arrives:_____ Departs: _____ Arrives:_____ Departs: _____ ☐ My child only comes on non-school days and summer.			**Kindergarten** ☐ Full ☐ Half Day **Head Start** ☐ Yes ☐ No		**Please check box if applicable** ☐ Child is living in the day care provider's home. ☐ Own ☐ Foster ☐ Other *Approved HEA is required to claim for reimbursement. ☐ Child is related to the provider. List relationship: _____				

Child's First then Last Name	Age	Date of Birth	Days Normally in Care / Meals* Normally Received While in Care (check all that apply): *B = Breakfast I A = AM Snack I L = Lunch I P = PM Snack I S = Supper I E = Evening Snack						
			Mon ☐B ☐A ☐L ☐P ☐S ☐E	Tues ☐B ☐A ☐L ☐P ☐S ☐E	Weds ☐B ☐A ☐L ☐P ☐S ☐E	Thurs ☐B ☐A ☐L ☐P ☐S ☐E	Fri ☐B ☐A ☐L ☐P ☐S ☐E	Sat ☐B ☐A ☐L ☐P ☐S ☐E	Sun ☐B ☐A ☐L ☐P ☐S ☐E
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VOLUNTARY CIVIL RIGHTS INFORMATION

Please check In the space provided, both the racial and ethnic identity of your child(ren), This information is voluntary and will not affect your child's eligibility, This information is being collected only to be sure that everyone receives a meal on a fair basis.

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

INFANT FORMULA OFFERED

As required by the CACFP, my provider has offered to supply _____ (Specify Brand of IFIF) for my infant(s}.

I accept offer. ☐ Yes ☐ No

By signing this form I understand that sponsors are required to randomly contact parents of registered children, either by phone or by mail, to verify provider's program participation. I agree to complete and promptly return any questionnaires received in the mail and/or answer any questions if contacted by phone concerning my child(ren)'s participation in the Child and Adult Care Food Program (CACFP). I understand that information on this form is being given in connection with the receipt of federal funds and that deliberate misrepresentation, on my part, may subject me to prosecution under applicable state and federal criminal statutes.

Date Child(ren) First Claimed	Signature of Parent or Legal Guardian	Printed Name of Parent or Legal Guardian	Email

Address, City and Zip	Home Phone #	Work Phone #

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or 2. fax: (833) 256-1665 or (202) 690-7442; or 3. email: Program.Intake@usda.gov

This !Institutlon Is an equal opportunity provider. **The United States Department of Agriculture requires the provider to keep a copy of this form.**