

Child and Adult Care Food Program

Child Participant Enrollment

Institution _____

Facility _____

Agreement #: _____

Dear _____

This center/program receives funding from the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs proof of enrollment for all children. Please complete the table below for each child in your family that is enrolled at this center/program. Be sure to sign and date in the space below. Thank you.

The information below should be completed by the parent or guardian.

Child's First Name	Child's Last Name	Date of Birth	Normal/Typical Hours of	Normal/Typical Days of Care(Circle all that	Meals Normally Eaten (Circle all that apply)
			to	M T W Th F Sat Sun ☐ ☐ ☐ ☐ ☐ ☐ ☐	B AM L PM S LPM ☐ ☐ ☐ ☐ ☐ ☐
			to	M T W Th F Sat Sun ☐ ☐ ☐ ☐ ☐ ☐ ☐	B AM L PM S LPM ☐ ☐ ☐ ☐ ☐ ☐
			to	M T W Th F Sat Sun ☐ ☐ ☐ ☐ ☐ ☐ ☐	B AM L PM S LPM ☐ ☐ ☐ ☐ ☐ ☐

Normal/Typical Hours of Care:

Please write in each child's usual arrival and departure time. Indicate a.m. or p.m.

Normal Days of Care: Please circle the days of the week each child is usually in attendance at the facility. (M-Monday; T-Tuesday; W-Wednesday; Th- Thursday; F-Friday; Sat-Saturday; Sun-Sunday)

Meals Normally Eaten- Please circle the meals each child usually eats at the facility.(B-Breakfast; AM-AM Snack; L-Lunch; PM-PM Snack; S-Supper; LPM-Late PM/Evening Snack)

Parent/Guardian Signature: _____ Date _____

Print Name: _____

Address _____

City: _____ State: _____ Zip Code: _____

Home Telephone _____ Work Telephone _____

Infant Feeding

Complete only if you have children under 12 months old. Choose one from each Category

Formula or Breast Milk

- ☐ I will provide breastmilk for my infant.
- ☐ I will provide iron-fortified infant formula for my infant. Formula brand: _____
- ☐ I want the site to supply iron-fortified infant formula. Formula brand: _____

Solid Food

- ☐ I will provide solid foods for my infant once they are developmentally-ready to eat
- ☐ I want the center or provider to supply solid foods for my infant once they are developmentally-ready to eat them.

For Facility/Provider Use Only:

Signature of Facility Representative/Provider: _____ Date: _____

Date each child withdrew: _____

For State Use Only: Complete _____ Incomplete _____ Reason: _____ Verified _____ Date _____

This institution is an equal opportunity provider.