

Institution Name: \_\_\_\_\_

Agreement Number: \_\_\_\_\_

Facility/Provider Name: \_\_\_\_\_

## Child and Adult Care Food Program (CACFP) Participant Enrollment Form

**Dear Parent/Guardian,**

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Sex:  Male  Female

Date participant enrolled in facility: \_\_\_\_\_

Food Allergies:  Yes  No If "yes", specify: \_\_\_\_\_

**(If the participant cannot be served the CACFP Meal Pattern, a statement from participant's Health Care Provider must be provided.)**

Check Days of Normal Care at facility:  Sunday  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday

Check Meals normally eaten at facility:  Breakfast  AM Snack  Lunch  PM Snack  Supper  Evening Snack

Please list the normal times of arrival and departure (**check am or pm**): **Arrive:** \_\_\_\_\_  am  pm. **Depart:** \_\_\_\_\_  am  pm

**If participant is an infant (0-11months), please complete this box. Check all applicable choice(s) below:**

**This institution/facility offers \_\_\_\_\_ formula for infants through the CACFP. It is your choice**  
(To be completed by facility/provider)  
**whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.**

- I will use the formula offered by this facility. I give permission for the formula to be mixed and/or bottles to be prepared for my infant by this facility's staff.
- I will not use the formula offered by this facility.  
If not, which formula will you send for your infant? \_\_\_\_\_  
If the formula you provide is a special formula, a medical statement must be submitted.
- I will provide breastmilk for my infant.
- My infant is four (4) months old or older and is developmentally ready for baby foods. I want the institution/facility to provide the following baby food(s) for my infant, which is/are allowed under 7CFR 226.20 (b)(2)(3)(4). \_\_\_\_\_

*Note to parents who are getting formula through the WIC Program: Your baby is eligible to get formula from this child care institution/facility as well as from the WIC Program. It is your decision which formula you want your baby to use when she/he is at child care. If you find you are getting more formula than your baby needs, you may wish to talk with your WIC nutritionist or your child care provider.*

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone Number: ( ) \_\_\_\_\_

Work Telephone Number: ( ) \_\_\_\_\_ Check Work Shift:  1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup>  Other (Specify) \_\_\_\_\_

**For Facility/Provider Use Only:**

Signature of Facility Representative/Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Date the participant withdrew: \_\_\_\_\_

In accordance with Federal Law and U.S Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.