

# Child & Adult Care Food Program Enrollment Form

This center or program participates in a meal program. The food program provides federal money in the form of reimbursement to the center for meals and/or snacks served to children in care through the United States Department of Agriculture, Child Nutrition Programs. We are required to collect this enrollment information and the parent's signature annually. Please complete the form below and return it to us. Please complete a separate form for each child. Site: Please UPDATE when Child Leaves

|  |  |   |                                   |       |       |
|--|--|---|-----------------------------------|-------|-------|
| Center Name  |  |   |                                   |       |       |
| Childs Name  |  |   |                                   |       |       |
| Child Date of Birth  |  |   |                                   |       |       |
| Normal Days in care<br>Please check  |  | <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> SA <input type="checkbox"/> SU |                                   |       |       |
| Normal Hours/Days in Care ( If hours vary by day, please be specific)<br><br>_____<br><br>Enrollment Date<br><br>_____<br><br>Withdrawal Date<br><br>_____ | Monday   |   |                                   |       |       |
|  | Tuesday  |   |                                   |       |       |
|  | Wednesday  |   |                                   |       |       |
|  | Thursday   |   |                                   |       |       |
|  | Friday   |   |                                   |       |       |
|  | Saturday   |   |                                   |       |       |
|  | Sunday   |   |                                   |       |       |
| Meals/Snacks received while in care  | Breakfast<br>AM Snack  | Lunch<br>PM Snack   | Supper<br>Evening Snack           |       |       |
| Special Diet Needs:  | This child has a food allergy or special diet need* Attach Doctor Note*<br>No   Yes If yes, please indicate: |   |                                   |       |       |
| Racial/Ethnic Data   | Hispanic or Latino   |   | Not Hispanic or Latino            |       |       |
|  | Black or African American  | Native Hawaiian or Other Pacific Islander   | American Indian or Alaskan Native | Asian | White |
|  |  |   |                                   |       |       |
| Parent's Signature:  | Date   | Printed Name  |                                   |       |       |
| Mailing Address  | Street Address/PO Box  |   |                                   |       |       |
|  | Town, State, Zip Code  |   |                                   |       |       |
| Telephone Number   |  |   |                                   |       |       |