Child Care Links
620-669-0291

Child & Adult Care Food Program
CACFP ENROLLMENT FORM

Effective dates:
October 1, 2016 - September 30, 2017

Do the days and times in care vary?
❑ Not Generally
❑ Frequently Explain:

Attend preschool? ❑ **Yes** ❑ **No**
Name:
Days and Hours…

Head Start? ❑ **Yes** ❑ **No**

Provider's Name _____ **Phone Number**_____ **Date Enrolled**_____

Only parents/guardians may complete enrollment information for each child enrolled.

Note to Parents/Guardians: Your child(ren) is enrolled for care at a family day care home that participates in the Child and Adult Care Food Program (CACFP). By participating in this program, the provider is serving a variety of nutritious foods to your child(ren) and receiving reimbursement to assist with food costs.

Important: You may receive a parent confirmation request to verify your child's attendance and the meals and snacks they are served. Your cooperation helps assure the continuance of this federally funded nutrition program.

Check one: ❑ First time enrollment for this family **OR** ❑ Update of enrollment information for this family

Child's first & last name *Printed*	Date of Birth	**Normal** Arrival Time	**Normal** Departure Time	**Circle Days of Care and Meals**													Ethnic/Race*	
				Normal Days of Care							**Normal** Meals Received During Care						Ethnicity	Race
				S	M	T	W	T	F	S	Br	AM Sn	Lu	PM Sn	Dn	BT Sn		
				S	M	T	W	T	F	S	Br	AM Sn	Lu	PM Sn	Dn	BT Sn		
				S	M	T	W	T	F	S	Br	AM Sn	Lu	PM Sn	Dn	BT Sn		
				S	M	T	W	T	F	S	Br	AM Sn	Lu	PM Sn	Dn	BT Sn		

* **Ethnicity:**
H - Hispanic or Latino
N - Not Hispanic or Latino

Race: (choose all that apply)
I - American Indian or Alaska Native
A - Asian
B - Black or African American
P - Native Hawaiian or Pacific Islander
W -White

Complete this section only if your child is under 1 year of age:

FORMULA offered by the child care provider: _____
Check one:

❑ I **accept** the above named formula for my infant. (A)

❑ I **decline** the above named formula for my infant. I will provide the formula. (B)

❑ I will provide **breast milk**. (B)

If providing breast milk, check one below:

❑ I accept the above named supplement formula.

❑ I will provide the supplement formula.

Solid Food – (Required at 8 months) Complete this section when your infant is ready for solid foods

❑ My infant is developmentally ready to be served baby food, infant cereal and/or table food,

starting _____(list date to begin).

Who will provide the baby food, infant cereal or table food for my infant?

❑ Provider will ❑ I will

_____
Printed ↑ Parent/Guardian First and Last Name

Address_____

City, State, Zip _____

Home Ph #_____Work Ph # _____

Work Place_____ Permission to call at work? ❑ Yes ❑ No

Parent's Signature_____Date_____

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Top copy is for Child Care Links, first white copy is for provider's records, and the back copy is for the parents