Child Enrollment Form FY 2012

Child & Adult Care Food Program

Dear Parent/Guardian:

Your **Family Day Care Provider:** _____ participates in the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) administered by the Massachusetts Department of Elementary and Secondary Education.

Meals served must meet nutrition requirements established by USDA's Child & Adult Care Food Program. In order to participate, your provider has agreed to follow the USDA guidelines. The Provider will give you a copy of the minimum meal components and portion requirements to be served according to the child's age. A medical statement from your doctor is necessary if your child cannot eat foods required by the CACFP.

In an effort to assess that these requirements are being met, the USDA and CACFP requires providers to annually collect the enrollment information listed below.

Please complete the form and return it to your Family Day Care Provider. Part 1 and Part 3 to be completed by all families or guardians. Part 2 to be completed ONLY if enrolling an infant child (under the age of 12 months).

PART 1: CHILD ENROLLMENT INFORMATION

Child's First Name	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care

Times Child Normally Attends For example 7:30 AM – 5 PM School Age Child – Times Child Attends School. For example 8:00 AM – 3:00 PM ✓ Box ☐ Schedule Varies	Hours from: _____ to _____ _____ to _____	Check the days your child normally attends ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday	Check the meals you request that your child receives while in care ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Child's First Name	Last Name	Child's Date of Birth & Age	Beginning Date of Child Care

Times Child Normally Attends For example 7:30 AM – 5 PM School Age Child – Times Child Attends School. For example 8:00 AM – 3:00 PM ✓ Box ☐ Schedule Varies	Hours from: _____ to _____ _____ to _____	Check the days your child normally attends ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday	Check the meals you request that your child receives while in care ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

If there are other children in care, please complete additional forms as needed.

For questions please contact: Child Care of the Berkshires, Terry Hartman (413)664-3256,

FOR SPONOSR OFFICE USE ONLY

Effective Date of this Enrollment Form: _____ Fiscal Year 2012

The effective date can be made retroactive back to the first day the child participates In the CACFP as long as it occurs in the same month this form is received.

PART 2: INFANT MEAL NOTIFICATION (Birth through 11 months)

Nutritious meals meeting the United States Department of Agriculture guidelines are served to all children enrolled in this program, including children under the age of 12 months. The Provider must meet the meal component requirements based on age and development outlined in the Infant Meal Pattern. The Provider will give you a copy of the minimum meal components and portion requirements to be served according to the child's age.

I understand that this Family Day Care Provider will serve a USDA approved formula _____ to my infant while in care.
(Name of Iron Fortified Infant Formula)

To help provide the best nutritional care for your infant, please complete the following information.

IF YOU *FORMULA-FEED* YOUR INFANT, PLEASE CHECK ONE OPTION

☐ I prefer to have the Provider supply the formula offered. **OR** ☐ I will supply formula for my infant child.

IF YOU *BREAST-FEED* YOUR INFANT, PLEASE CHECK

☐ I will supply expressed (pumped) breast milk for my infant child.

I understand that this Family Day Care Provider will supply infant cereal and infants foods for infants 4 months and older as they are developmentally ready according to the CACFP requirements.

☐ I prefer to have the Provider supply infant cereal and infant foods. **OR** ☐ I will supply infant cereal and infant foods for my infant child.

PART 3: PARENT OR GUARDIAN ACCEPTANCE AND SIGNATURE

I have read this child enrollment form and request that my child receive the above Child and Adult Care Food Program benefits. I have received a copy of this completed form and the "Building For The Future" Flyer.

Parent or Guardian Signature — Date Signed (form must be completed annually)

Parent's Name: _____ Home Phone: _____
Guardian Name: Please Print

Mailing Address: _____ Work Phone: _____

City, State, Zip: _____ Cell Phone: _____

CIVIL RIGHTS: This information is voluntary and will not affect your children's eligibility. Please indicate the ethnic and racial identity of your children by checking a box in each of the categories. This information is being collected to assure that everyone receives CACFP benefits on a fair basis.

1. **Ethnic Identity** ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO.
2. **Racial Identity** ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN
   ☐ NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER ☐ WHITE.

Medical Statement for Children Requiring Special Meals in the Child and Adult Care Food Program

FY 2012

Note: According to 7 CFR, part 226.20, food substitutions for medical reasons can be made only when there is a written statement from a medical authority. This written statement must include the medical reason and recommended alternate foods.

Part I (***To be filled out by Child Care Center/Provider***)

Date: _____ Name of Child: _____

Center/Home Attended by Child: _____

Part II (***To be filled out by Medical Authority***)

Patient's Name: _____ Age: _____

Diagnosis: _____

_____

_____

_____

Describe the medical or other special dietary needs that restrict the child's diet: _____

_____

_____

List food(s) to be **omitted** from the diet and food(s) to **be substituted** (Diet Plan): _____

_____

_____

_____

_____

_____ _____

Date Print Name

_____

Signature of Medical Authority

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, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.