



For questions please contact: Provider Resources Inc. 411 Merrimack St STE 100, Methuen, MA 01844 781-939-9292

PROVIDER'S NAME _____ SITE # _____

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 this form and return it to your Family Child Care Provider:

CHILD # ASSIGNED _____

PART 1: CHILD ENROLLMENT INFORMATION

Child's First Name	MI	Last Name	Child's Date of Birth	Age	Beginning Date of Child Care
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Relation: (Child's relation to the Provider)		Sex:	REGULAR SCHEDULE		VARIED SCHEDULE
<input type="checkbox"/> Not Related. <input type="checkbox"/> Provider's Foster child* <input type="checkbox"/> Related -Non-Resident <input type="checkbox"/> Provider's Own child**		<input type="checkbox"/> Male <input type="checkbox"/> Female	Check the days your child normally attends.		<input type="checkbox"/> Check here & select additional ALTERNATIVE days care may be needed due to a varied work schedule.
			REGULAR SCHEDULE - DAYS <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <i>If Weekends:</i> <input type="checkbox"/> Wednesday <input type="checkbox"/> Saturday <input type="checkbox"/> Thursday <input type="checkbox"/> Sunday <input type="checkbox"/> Friday		

* If enrolling your foster child, please call the office
 **If enrolling your own child, submit Income Eligibility Form

MEAL PARTICIPATION SCHEDULES

INFANT to PRESCHOOL CHILD		SCHOOL AGE CHILD (fill in both schedules: "IN SCHOOL" & "NO SCHOOL")			
SCHEDULE		SCHEDULE: IN SCHOOL		SCHEDULE: NO SCHOOL	
Normal times in care For example 7:30 AM – 5 PM Earliest drop off and latest pick up _____ to _____		Normal times in care For example AM _____ to _____ AM 7:30 – 9:00 PM _____ to _____		Normal times in care For example 7:30 AM – 5 PM Earliest drop off and latest pick up _____ to _____	
Check meals your child receives while in normal times in care: <i>If Evening care:</i>		Times child normally attends school: _____ to _____		Child attends full day during school closures: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Supper <input type="checkbox"/> AM Snack. <input type="checkbox"/> PM Snack <input type="checkbox"/> Eve Snack		<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Supper <input type="checkbox"/> AM Snack. <input type="checkbox"/> PM Snack <input type="checkbox"/> Eve Snack		Check meals your child receives while in care on a School Day: <i>If Evening care:</i> <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Supper <input type="checkbox"/> AM Snack. <input type="checkbox"/> PM Snack <input type="checkbox"/> Eve Snack	
Check meals your child receives while in care when School is Closed: <i>If Evening care:</i>		Check meals your child receives while in care when School is Closed: <i>If Evening care:</i> <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Supper <input type="checkbox"/> AM Snack. <input type="checkbox"/> PM Snack <input type="checkbox"/> Eve Snack			

(IF enrolling an INFANT [Birth – 11 months old], complete this section to provide the best nutritional care for your Infant.)

When NOT IN CARE:	While IN CARE:	FORMULA Information	
Normally your child is fed: <input type="checkbox"/> This child is Breast-fed <input type="checkbox"/> This child is Formula-fed	<input type="checkbox"/> I will supply breast milk (expressed or on-site) <input type="checkbox"/> I will supply Formula -Fill in the Formula information => <input type="checkbox"/> Provider will supply Formula -Fill in the Formula information=>	Name of Iron Fortified Infant Formula:	IF the Provider supplies Formula: (optional)
		<input type="checkbox"/> I also wish to supply ONE other creditable food item Name of item:	

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 developmental readiness as outlined in the Infant Meal Pattern.

Parents/Guardians may supply not more than one component in the meal pattern (including breast milk or formula) in order for the meal to be reimbursable in CACFP).

PART 2: PARENT OR GUARDIAN ACCEPTANCE AND SIGNATURE

PARENT OR GUARDIAN NAME:		HOME PHONE
MAILING ADDRESS:		CELL PHONE
CITY:	STATE:	ZIP CODE:

SIGNATURE

I have read this child enrollment form and I DO request that my child receive the above CACFP benefits. I have received a copy of this completed form and the "Building For The Future" Flyer. Also, as applies, I understand that this Family Day Care Provider will supply infant cereal and infant foods for infants 4 months and older as they are developmentally ready according to the CACFP requirements.

OR-> I have read this child enrollment form and I DO NOT request that my child receive the above CACFP benefits

PARENT OR GUARDIAN SIGNATURE		DATE (must be renewed annually)
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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 ensure that everyone receives CACFP benefits on a fair basis.			
1. Ethnic Identity	<input type="checkbox"/> HISPANIC OR LATINO	<input type="checkbox"/> NOT HISPANIC OR LATINO	
2. Racial Identity	<input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE	<input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	<input type="checkbox"/> ASIAN
	<input type="checkbox"/> BLACK OR AFRICAN AMERICAN	<input type="checkbox"/> WHITE	

This institution is an equal opportunity provider.

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.

FOR SPONSOR OFFICE USE ONLY: Effective Date of this Enrollment Form: _____
 Fiscal Year: _____