Child and Adult Care Feeding Program
Enrollment Form

Provider's Initials: _____

Date: _____

To be completed by Parent or Guardian

Instructions: Thank you for choosing a childcare provider that participates in the USDA Child and Adult Care Food Program (CACFP). This program helps provide nutritious meals and snacks to children in care. Please complete this form to help maintain accurate enrollment records. Daily menus and meal schedules should be posted and available for your review at the facility. If you have questions about CACFP, please contact the Arkansas Department of Agriculture, Food and Nutrition Division, at (501) 324-9502.

Name of Day Care Facility _____ Telephone # _____

Address _____ City _____ State _____ Zip Code _____

The following information is required by USDA Federal Regulation CFR 226.15(e)(2).

I wish to enroll my child(ren), whose names and enrollment information are specified below, in the USDA Child and Adult Care Food Program (CACFP). I understand this program reimburses day care facilities for serving nutritious and well-balanced meals/snacks to day care children.

My Child(ren) will be served the following meals:

Breakfast: ____ AM Snack: ____ Lunch: ____ PM Snack: ____ Supper: ____ Late Snack: ____

Please Print Child(ren)'s Information						
First Name	Last Name	Age	Birth Date	Hours of Care	Days of the Week	Gender
				From: To:	Mon. ☐ Thur. ☐ Sun. ☐ Tues. ☐ Fri. ☐ Wed. ☐ Sat. ☐	
				From: To:	Mon. ☐ Thur. ☐ Sun. ☐ Tues. ☐ Fri. ☐ Wed. ☐ Sat. ☐	
				From: To:	Mon. ☐ Thur. ☐ Sun. ☐ Tues. ☐ Fri. ☐ Wed. ☐ Sat. ☐	
				From: To:	Mon. ☐ Thur. ☐ Sun. ☐ Tues. ☐ Fri. ☐ Wed. ☐ Sat. ☐	
				From: To:	Mon. ☐ Thur. ☐ Sun. ☐ Tues. ☐ Fri. ☐ Wed. ☐ Sat. ☐	

Please identify any food allergies or special needs your child(ren) require:

Doctor's Name:_____ Doctor's Telephone: _____

Optional Racial and Ethnic Information - This information is voluntary and is collected solely for civil rights compliance and reporting purposes. Providing this information will not affect your child's participation in CACFP. By completing this section, you help ensure that the program is administered fairly and in a nondiscriminatory manner for all participants.

Participant's Ethnic and Racial Identities **Please select all that apply**

			Ethnic	**Racial Data**				
Name of Enrolled Child(ren)	Age	Foster Child?	Hispanic or Latino	American Indian or Alaskan Native	Asian	Black or African American	Hawaiian Native or Other Pacific Islander	White

I understand my child(ren) will receive meals at no extra charge to me when they are in care during any scheduled meal service and receive meals. I understand that the day care facility cannot and will not discriminate for reasons of race, color, national origin, sex (including gender identity or sexual orientation), or disability. There is to be no discrimination in admission policy, meal service, or use of facility. Any complaints should be addressed to: USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD).

EMERGENCY CONTACT INFORMATION:

Home Telephone #:_____ Work Telephone #: _____

_____

Parent's Address City State Zip Code

Parent's Signature: _____ Date: _____

*Form expires one (1) year from this date