Child Enrollment Form for the Child and Adult Care Food Program
Family Day Care Home

CHILD(REN)'S INFORMATION:

Child's Name (1) _____ Date of Birth _____ / _____ / _____
Month Day Year

Child's Name (2) _____ Date of Birth _____ / _____ / _____
Month Day Year

Home Address _____ *Home Phone* _____

Normal Days of Care with the Provider: ___S ___ M ____T ___W ____TH ___F ___S ☐ Check if Parent works multiple shifts

Normal Hours of Care with the Provider: _____ AM _____ PM

Meal Participation with the Provider ____Breakfast _____Snack (AM) ____Lunch _____Snack (PM) _____Supper

SCHOOL INFORMATION:

School/Child Care Center (1) _____ Grade (1) _____

School/Child Care Center (2) _____ Grade (2) _____

My child(ren) participate(s) in the following meals at school, Head Start center, or child care center:
[ ] Breakfast [ ] AM Snack [ ] Lunch [ ] PM Snack [ ] Supper

PARENTAL INFORMATION:

Mother's Name _____ Work Hours _____
Work Name & Address _____ Work Phone
_____ Home Phone _____

Father's Name _____ Work Hours _____
Work Name & Address _____ Work Phone
_____ Home Phone _____

Are there any unusual guardianship or custodial relationships? _____
_____

Persons authorized to pick up child(ren) _____
Special Needs of Child (1) _____
Medical Information (allergy, sickness, etc.)(1) _____
Special Needs of Child (2) _____
Medical Information (allergy, sickness, etc.)(2) _____
In case of injury of accident _____ _____ _____
Physician's Name *Physician's Phone* *Hospital of Choice*

I hereby give permission to treat my child(ren) in case of medical emergency.

_____ _____ _____
Parent's Signature *Parent's Signature* *Date*

NAMES OF TWO OTHER PERSONS THAT CAN BE CONTACTED IN CASE OF EMERGENCY

Name _____	Name _____
Address _____	Address _____
_____	_____
Phone _____	Phone _____

My child (1) is: [ ] Related to Provider: Relationship_____ [ ] Paying for Care
[ ] Not Related to Provider [ ] Not Paying for Care [ ] Notarized Statement on file

My child (2) is: [ ] Related to Provider: Relationship_____ [ ] Paying for Care
[ ] Not Related to Provider [ ] Not Paying for Care [ ] Notarized Statement on file

I understand that my provider has applied to receive federal funds for meals served to my child(ren) and that I may be contacted to verify my child(ren)'s attendance. I have attached current immunization record(s) for my child(ren).

Child's Age (1) _____ _____ Enrollment Date (1) _____ Withdrawal Date (1) _____
Reason for Withdrawal _____

Child's Age (2) _____ _____ Enrollment Date (2) _____ Withdrawal Date (2) _____
Reason for Withdrawal _____

NOTE: Providers **MUST** retain emergency contact information for every child. Sponsors should retain a copy of this form to validate enrollment**.**

Revised 2/2005
CACFP
FSFA