

Child and Adult Care Food Program Enrollment Form



Day Care Provider

Provider Name: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____

Enrollment(s) Information

Name of CACFP Participant _____ / ____ / ____ Date of Birth _____ M F
Circle

Hispanic/Latino NOT Hispanic/Latino Choose one ethnicity – required for statistical reporting	White Black American Indian/ Alaskan Native Native Hawaiian/ Pacific Islander Asian Choose one or more regardless of ethnicity- required for statistical reporting
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Start Date: ____/____/____ Shift Work: Y N Arrival Time: ____ am/pm Departure Time: ____ am/pm

Normal days of week Participant(s) in care: MON TUE WED THU FRI SAT SUN
Circle all that apply

Meals eaten: Breakfast AM Snack Lunch PM Snack Supper Evening Snack
Circle all that apply. CACFP provides reimbursement for up to 2 approved meals and one snack/day/participant

Parent / Guardian / Participant

Name: _____

Address: _____ Contact Phone: _____

City: _____ State _____ Zip: _____

Signature: _____ Date: ____/____/____

Sponsor Use Only

Determining Official: _____ Date: ____/____/____ Participant/s Exit Date: ____/____/____

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