Child and Adult Care Food Program
Enrollment Form

Day Care Provider

Provider Name: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____

Enrollment(s) Information

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

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

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

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Parent / Guardian / Participant

Name: _____

Address: _____ Contact Phone: _____

City: _____ State _____ Zip: _____

Signature: _____ Date: _____/_____/_____

Sponsor Use Only

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