ENROLLMENT FORM

Provider Number: _____

Provider's Name: _____

CHILD'S INFORMATION							
Child's Name:					Date of Birth:		
Normal Days in Attendance:	☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday	☐ Friday	☐ Saturday
School Age—Hours Attend				AM ☐	PM ☐	All Day ☐	NA ☐
Special Dietary Needs (Attach signed medical statement):						Yes ☐	No ☐
Normal Hours of Attendance:			a.m./p.m.		to		a.m./p.m.
Normal Meals Eaten:	☐ Breakfast	☐ AM Snack	☐ Lunch	☐ PM Snack	☐ Supper	☐ LatePM Snack	

Race (Optional):	Ethnicity (Optional):
☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African ☐ Hawaiian or Pacific Islander ☐ White	☐ Hispanic ☐ Not Hispanic

PARENT'S INFORMATION
Name of Parent/Guardian:
Address:
City, Zip
Email Address:
Telephone Number:

I certify that all information on this form is true and accurate. I understand that the provider will get federal funds based on the information that I give. I understand that CACFP officials may verify the information. I understand that if I purposely give false information, this participant receiving meals may lose the meal benefits and I may be prosecuted.

_____ _____

Parent/Guardian Signature Date

_____ _____

Provider Signature Date