

COLUMBIA BASIN EDU-CARE ASSOCIATION

COLUMBIA BASIN EDU-CARE ASSOCIATION USDA FOOD PROGRAM ENROLLMENT FORM

(TO BE FILLED OUT BY THE PARENT OR GUARDIAN ONLY)

Provider's Own Child(ren)
<input type="checkbox"/> Yes

Provider Number

For enrollment in the Child and adult Care Food Program of:

PLEASE PRINT

Day Care Provider's Name

PLEASE PRINT

I wish to enroll my child/children whose names and enrollment information are given below, in the United States Department of Agriculture (USDA) Child and Adult Care Food Program which reimburses day care providers for serving nutritious, well balanced meals to day care children.

Child File Number	Name of Child	Birthdate	Usual Hours in Care		Usual Meals Needed: (Mark X for occasional)						
			From	To	Break fast	AM Snack	Lunch	PM Snack	Supper	Late Snack	

Formula Options for Infants	
<input type="checkbox"/> (1) Parent Supplies Food and Formula (NC)	<input type="checkbox"/> (4) Parent Supplies Formula and Provider Supplies Food (13)
<input type="checkbox"/> (2) Parent Accepts Formula Provider Offers (11)	<input type="checkbox"/> (5) Doctor Statement (Milk Allergy) (12)
<input type="checkbox"/> (3) Parent Supplies Breast Milk (11)	Formula Offered _____

Days in care on a normal week (CIRCLE): Mon Tues Wed Thur Fri Sat Sun

Note here other hours and meals when child/children will occasionally be served, or other special information disabled children or children with food allergies. A statement from a recognized medical authority must accompany this form if your child/children has/have special food needs or allergies. The statement must include substitute foods:

I understand my child/children will receive meals at no charge to me when they are in care during any of the scheduled meal services. I have received a copy of Program Aid Number 1299 which explains the goals of the Child Care Food Program. I understand that the day care home cannot and will not discriminate for reasons of race, color, national origin, gender, age or disability. I understand that I may be contacted by the sponsor regarding meals claimed by the provider for my child. If I need to be contacted by phone to update and /or verify this information at some time, I would prefer being called at:

Work Home

PARENT'S NAME (Print)	
PARENT'S SIGNATURE	DATE (meals may not be claimed prior to this date)
ADDRESS	

HOME TELEPHONE NUMBER ()
WORK TELEPHONE NUMBER ()
START DATE

YOUR RACIAL- ETHNIC HERITAGE

Although you are not required to provide this information, your cooperation will help determine compliance with Federal Civil Rights Law. In no instance will this information be used in considering your application. If you decline to provide this information, it will in no way affect consideration of your application. We are authorized to ask for this information under Title VI of the Civil Rights Act of 1964. **Collection of this information is strictly for statistical reporting requirements. Please check the correct category below.**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Black - not of Hispanic Origin	Hispanic	Asian or Pacific Islander	American Indian or Alaskan Native	White - not of Hispanic Origin

Confidentiality

The information you provide will be treated confidentially and will be used only for eligibility determination and verification of data for Child and Adult Food Program purposes.