Dear Parents:
Your Day Care Home Provider has chosen to join the Child and Adult Care Food Program (CACFP). This program extends the National School Lunch program to children in Family and group child care homes. The USDA has guidelines that your provider has agreed to follow.

Under the regulations of the CACFP, your Day Care Home Provider may NOT charge you a separate fee for meals that are claimed for reimbursement, and they must supply all of the components needed to meet the requirements. In an effort to improve our Program, we periodically contact parents to provide input and to verify attendance of their children in this child care home.

I have verified that the information is correct, and I have received a copy of this completed form and the Building For The Future Flyer.

Parent/Guardian Signature: ____________________________ Date: ____________

DCH Provider’s Signature: ____________________________ ID#: ____________

The U.S. Department of Agriculture (USDA) prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal and, where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or if all or part of an individual’s income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complain Form, found online at http://www.ascr.usda.gov/complain_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complain form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Ave, S.W., Washington, D.C. 20250-9410, by fax (202)690-7442 or email at program.intake@usda.gov.individuals who are deaf, hard of hearing, or have speech disabilities and wish to file either an EEO or program complain please contact USDA through the Federal Relay Service at (800) 877-9339 or (800)845-6136 (in Spanish). Persons with disabilities who wish to file a program complain, please see information above on how to contact us by mail directly or by email. If you require alternative means of communication for program information (e.g., Braille, large print, audiotape, etc.) please contact USDA’s TARGET center at (202) 720-2600 (voice and TDD). USDA is an equal opportunity provider and employer.

CCFP Child Care Food Program
150 River Oaks Pkwy | San Jose, CA 95134 | P. 408.457.3139 | F. 408.645.1611 | www.4C.org

Status: □ P □ A

Received by: ____________________________ Date: ____________

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Provider:  
Phone:  
Address:  

CHILD ENROLLMENT REPORT

Child Care Food Program  
150 River Oaks Parkway F-1  
San Jose CA 95134

CHILD INFO:
First Name:  
MI:  
Last Name:  
Ethnicity:  
Race:  
City:  
State:  
Address:  
Zip Code:  
Sex:  M  F  
Date of Birth:  
Enrollment Date:  
Withdrawal Date:  
Provider’s Own:  ☐ YES  ☐ NO

PARENT INFO:
First Name:  
MI:  
Last Name:  
Address:  
City:  
State:  
Zip Code:  
Sex:  M  F  
Email Address:  
Phone:  Home:  Work:  Cell:  

NORMAL SCHEDULE:
Participating Days:  MON  TUES  WED  THURS  FRI  
Days Vary:  ☐ YES  ☐ NO
Time Range:  
Times Vary:  ☐ YES  ☐ NO
Participating Meals:  B  AMS  L  PMS  D  EveS

SPECIAL INFO:
School Name:  
Participates in CACFP:  ☐ YES  ☐ NO
School District:  
Special Diet:  ☐ YES  ☐ NO
Days Attend:  MON  TUES  WED  THURS  FRI
Special Needs:  ☐ YES  ☐ NO
School Depart/Return Times:  
If Yes, is marked for either Special Diet or Special Needs, attach a physician signed medical statement.

BREAST MILK AND IRON-FORTIFIED INFANT FORMULA (IFIF):

Your Provider is required to offer Iron-Fortified Infant Formula (IFIF) to your infant and must inform you of the brand offered. It is your choice whether or not to use this formula based on your preference and your infant’s needs. You may choose to supply breast milk or formula for your infant. If you accept the formula offered by the provider, you give your permission for the formula to be mixed for your infant by the facility staff. You may be required to provide sufficient sanitized bottles each day for your child’s use. If this is required, the bottles must be labeled with your child’s name/date and be taken home daily. If you choose to supply breast milk for your infant, write “Parent Supplies Breast milk or IFIF” on this form. If you refuse the provider’s formula and choose to supply formula for your infant, you must write the brand of formula and you will be supplying in the space provided on this form and write “Parent Supplies Breast milk or IFIF” on this form. If the formula you provide is low-iron fortified, non-iron fortified, or a specially formula, a medical statement is required.

When your infant is four months old or older and is developmentally ready for baby food, your provider is required to offer additional, supplemental foods in compliance with the infant meal pattern as required by 7CFR226.20. These foods will include iron-fortified infant cereal, fruits vegetables, meats, and meat alternates, when developmentally appropriate for your child. You have the option of supplying these supplemental foods and refusing the Provider’s supplemental foods.

Not to parents who receive formula through the WIC program: Your infant is eligible to receive formula from this child care facility as well as from the WIC program. It is your decision which formula you want your infant to use when in child care.

Formula:  
Formula Offered by Provider:  
Formula Offered by Parent:  

School Name:  
Participates in CACFP:  ☐ YES  ☐ NO
Special Diet:  ☐ YES  ☐ NO  
Special Needs:  ☐ YES  ☐ NO
School Depart/Return Times:  
If Yes, is marked for either Special Diet or Special Needs, attach a physician signed medical statement.

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Formula:  
Formula Offered by Provider:  
Formula Offered by Parent: