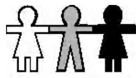

Yours for Children, inc.

Child's YFCI Enrollment Number (Paper claims only)	______________

303-313 Washington Street
Auburn, MA 01501
800-222-2731
FAX 508-721-0919
E-Mail: yfci@yoursforchildren.com
www.yoursforchildren.com

Please check (✓) one option:

☐ **New Child Enrollment** ☐ **Updated Child Enrollment** ☐ **Reactivation**

Beginning Date _______________

CACFP CHILD ENROLLMENT FORM **PLEASE PRINT**

Your Family Day Care Provider participates in the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) administered by the Massachusetts Department of Elementary and Secondary Education. Meals served must meet nutrition requirements established by USDA's Child & Adult Care Food Program. In order to participate, your provider has agreed to follow the USDA guidelines. A medical statement from your doctor is necessary if your child cannot eat foods required by the CACFP. In an effort to assess that these requirements are being met, the USDA and CACFP requires providers to annually collect the enrollment information listed below.

Please complete the form and return it to your Family Day Care Provider. Part 1 and Part 3 to be completed by all families or guardians.
Part 2 to be completed ONLY if enrolling an infant child (under the age of 12 months).

PART 1: CHILD ENROLLMENT INFORMATION

____________________________ ____________________________ ____/____/____ M _____ F _____

Child's First Name **Last Name** **Date of Birth** **Gender**

Times Child Normally Attends
For example 7:30 AM – 5 PM

Hours from:
________ to _________

Check (✓) the days your child normally attends:

☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

School Age Child –
Times Child Attends School.
For example 8:00 AM – 3:00 PM

School Hours from:
________ to _________

Child attends full day during school closures: ☐ Yes ☐ No

Check (✓) the meals you request that your child receives while in care:

☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Check (✓) Child's Relation to Provider:
☐ Not related
☐ Related, Non-resident
☐ Child Resides with Provider

PART 2: INFANT MEAL NOTIFICATION (Birth through 11 months)

Nutritious meals meeting the United States Department of Agriculture guidelines are served to all children enrolled in this program, including children under the age of 12 months. The Provider must meet the meal component requirements based on age and development outlined in the Infant Meal Pattern.

I understand that this Family Day Care Provider will serve the iron fortified formula ___________________________ to my infant while in care.
(Name of Iron Fortified Infant Formula)

To help provide the best nutritional care for your infant, please complete the following information.

IF YOU *FORMULA-FEED* YOUR INFANT, PLEASE CHECK (✓) ONE OPTION:
☐ I prefer to have the Provider supply the formula offered, OR
☐ I will supply formula for my infant child

IF YOU *BREAST-FEED* YOUR INFANT, PLEASE CHECK (✓):
☐ I will supply expressed (pumped) breast milk for my infant child

I understand that this Family Day Care Provider will supply infant cereal and infants foods for infants 6 months and older as they are developmentally ready according to the CACFP requirements. Please check (✓) one option.
☐ I prefer to have the Provider supply infant cereal and infant foods. OR
☐ I will supply infant cereal and infant foods for my infant child.

PART 3: PARENT OR GUARDIAN ACCEPTANCE AND SIGNATURE

Civil Rights: This information is voluntary and will not affect your children's eligibility. Please indicate ethnic **and** racial identity of your children by checking a box in EACH of the categories. This information is being collected only to be sure that everyone receives CACFP benefits on a fair basis.

1. Ethnic Identity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
2. Racial Identity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Island ☐ White

____
Parent/Guardian, Please Print Name

____________________________________ ________ ________________________ _________ ___________
Mailing Address **Apt #** **City** **State** **Zip**

(__________)______________________ (__________)______________________ (__________)_____________
Home Telephone Number **Cell Telephone Number** **Work Phone Number**

I have read this Child Enrollment Form and request that my child receive the above CACFP benefits. I have received a copy of this completed form.

PARENT/GUARDIAN SIGNATURE_________________________________ **DATE SIGNED**_______________________

PROVIDER NAME: ____ **PROVIDER #** ______________________

This institution is an equal opportunity provider.

White: YFCI **Yellow:** Provider **Pink:** Parent YFCI 08/2017

For YFCI use only: Effective Date of this Enrollment Form __________________ Fiscal Year ____________
The effective date can be made retroactive back to the first day the child participates In the CACFP as long as it occurs in the same month this form is received.