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CHILD AND ADULT CARE FOOD PROGRAM FORMS FOR CHILD CARE CENTERS

CHILD AND ADULT CARE FOOD PROGRAM
ATTENDANCE / MEAL COUNT SHEET FOR CENTERS

(Legend: ATT = Daily Attendance; B = Breakfast; L = Lunch; SN = Snack)

CENTER:																							
CLASSROOM:	Day: MON.				Day: TUES.				Day: WED.				Day: THUR.				Day: FRI.						
DATE:	/ /				/ /				/ /				/ /				/ /						
NAME	ATT	B	L	SN	ATT	B	L	SN	ATT	B	L	SN	ATT	B	L	SN	ATT	B	L	SN	ATT	B	L	SN
TOTAL ALL COLUMNS																							
FOR OFFICE USE ONLY- FREE																							
FOR OFFICE USE ONLY- REDUCED																							
FOR OFFICE USE ONLY- PAID																							

Updated May 2013

Parent Choices for Infant Meals

Children & Families First Child and Adult Care Food Program

Home/Center Provider Name _____

Dear Parent:
This home/center offers _____ Formula** as part of the Child and Adult Care Food Program (CACFP) to children less than 12 months of age. We are pleased to offer these benefits for as long as this home/center is eligible to participate in the CACFP.

We are required to follow the USDA Infant Meal Pattern at no additional charge. To better meet your personal preferences and your infant's needs, you may choose from the listed options. Please check your selection, sign, and date this form. Please update this form as your child matures and/or as you change your preferences. Please update immediately if your pediatrician changes your infant's formula. Every infant enrolled at the home/center is required to have this completed and updated form on file.

If your infant's formula is currently not _____, we strongly recommend that you check with your pediatrician before switching. You may choose to use our formula at no extra charge or continue to provide your own brand.

****Please note: We are providing formula to be used at the home day care/center ONLY.**

Infant's First & Last Name_____ Date of Birth_____

FORMULA CHOICES

_____**I accept the** _____ **Iron Fortified Infant Formula offered by the home /center.**

_____**I decline the formula offered by the home /center.** (Choose one of the following)

_____ **I will provide the following iron fortified formula:** _____
Formula Type Required

_____ **I will provide breast milk for my child.**

_____ ***I will provide a non-approved low Iron Formula and a Medical Statement.***

FOOD CHOICES:

_____**When my child is developmentally ready I accept the following infant foods offered by the home/center:**

☐ **IRON FORTIFIED INFANT CEREAL** ☐ **VEGETABLES** ☐ **FRUITS** ☐ **INFANT MEATS/MEAT ALTERNATE**

A copy of the home/center menu is available upon request. Foods we offer may include but are not limited to:
Infant Cereal-Rice, Oat, Barley
Vegetables-Carrots, Green Beans, Peas, Squash, Sweet Potatoes
Fruits-Applesauce, Bananas, Peaches, Pears
Meat / Meat Alternates-Beef, Chicken, Turkey, Beans, Cheese
Whole grain breads/crackers (8-11 months only)
Please discuss individual needs with your child's caregiver.

_____**I decline all infant food offered by the home /center.**

PARENT'S SIGNATURE: _____DATE_____

Provider/Center Name:_____ **Child and Adult Care Food Program**
Income Eligibility Form

PART 1 *(This part must be completed for all participants. Enter the participant(s) name and information.)*

Participant's Name: _____ **DOB:** _____
Last First Middle Initial

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)

Participant's Name: _____ **DOB:** _____
Last First Middle Initial

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: _____ **Arrival Time:** _____ **AM/PM** **Departure Time:** _____ **AM/PM** **Shift Work: Yes/No**

***Normal* days of week Participant(s) is/are in care** *(circle all that apply):* **Mon Tues Wed Thurs Fri Sat Sun**

Meals eaten at Providers/Center: (*Circle all that apply. CACFP provides reimbursement for up to 2 approved meals and one snack per day/participant*):
Breakfast **AM Snack** **Lunch** **PM Snack** **Supper** **Evening Snack**

PART 2A – HOUSEHOLDS NOW GETTING SNAP OR TANF: *Complete this Part; skip to Part 3 to sign and date this form.*
SNAP Case Number (i.e., Food Stamp): _____ **TANF Case Number:** _____

PART 2B – FOSTER CHILD - Check box if a foster child: ☐* (The legal responsibility of a welfare agency or court.) Include personal income earned by the foster child only. Foster payments received by the family from the placing agency are not considered income and do not need to be reported. Write the child's income: _____ ☐ Month/☐Year. ***A copy of the State or local agency document indicating a child's foster status is required to be on file at the child care institution.** *Complete this part; skip to Part 3 to sign and date this form.*

PART 2C – HOMELESS - Check Box if homeless: ☐ *Complete this part; skip to Part 3 to sign and date this form.*

PART 2D – HOUSEHOLD INCOME – *If you do not need to complete Part 2A, 2B or 2C, complete this Part and Part 3 to sign and date this form.*

NAMES — CURRENT INCOME **(Please indicate by income as weekly, bi-weekly, 2x's a month, monthly or yearly)**

List Names of All Household Members (Attach Any Additional Members)	Earnings from Work (Before Deductions) Job 1	Welfare, Child Support, Alimony	Payments from Pensions, Retirement, Social Security	Earnings from Job 2 or any Other Income
(Example) - Jane Smith	$200/weekly	$150/twice a month	$100/monthly	$
1	$	$	$	$
2	$	$	$	$
3	$	$	$	$
4	$	$	$	$
5	$	$	$	$

PART 3 – SIGNATURE and LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: An adult household member must **sign and date** this form before it can be approved. If Part 2D is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

PENALTIES FOR MISREPRESENTATION: I certify that all of the above information is true and correct, that the SNAP or TANF Number is correct, and that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the statement, and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Printed Name of Adult _____ **Signature of Adult** _____ **Date** _____

Home Address: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Last four digits of Social Security Number: *_*_*_ - *_*_ - ____ ____ ____ ____ ☐ I do not have a Social Security Number

SPONSOR USE ONLY: Categorical Eligibility (If Yes, Check One): ☐ SNAP (Food Stamp) Household ☐ TANF Household ☐ Head-Start ☐ ECAP ☐ Foster Child(ren) ☐ Homeless Participant(s)

DATE WITHDRAWN: _____

Total Family Income: _____ Family Size: _____ (Include all Participants)

Yearly Income Conversion: ***Weekly x 52; Every Two Weeks x 26; Twice a Month x 24; Monthly x 12***

ELIGIBILITY - Based on the information provided this application will be:
☐ Approved FREE ☐ Approved REDUCED ☐ Denied – The meals will be claimed in the PAID category.

Determining Official Signature: _____ Review/Effective Date: _____

Revised: **9/25/12**

Instructions for Completing the Child and Adult Care Food Program Income Eligibility Form (Child Care)

Please complete the Child and Adult Care Food Program Income Eligibility Form using the instructions below. Sign the form and return it to the center/sponsor. Call the center/sponsor if you need help. Telephone Number: **(302) 479-1683**.

PART 1: PARTICIPANT'S INFORMATION: **ALL HOUSEHOLDS** COMPLETE THIS PART.

(1) Print the name or names of the Participant(s) enrolled.
(2) RACIAL/ETHNIC IDENTITY: COMPLETE THE RACIAL/ETHNIC IDENTITY. You are not required to answer this question to get meal benefits. This information will help ensure that everyone is treated fairly.
(3) Start date, arrival and departure times, normal days and normal meals must be completed at the time of enrollment and/or renewal.

PART 2A: ONLY HOUSEHOLDS GETTING SNAP OR TANF BENEFITS: COMPLETE THIS PART AND PART 3.

(1) List your current SNAP Case Number or your TANF Identification Number for the participant. DO NOT complete Part 2B, 2C or 2D.
(2) An adult household member must sign the form in Part 3.

PART 2B: ONLY HOUSEHOLDS ENROLLING A FOSTER CHILD: COMPLETE THIS PART AND PART 3. Refer to specific instructions indicated. List all foster children. Check the box indicating that the child is a foster child.

PART 2C: HOMELESS ENROLLEES **ONLY**. CHECK THE BOX AND COMPLETE PART 3.

PART 2D: ANY HOUSEHOLD REPORTING TOTAL HOUSEHOLD INCOME. COMPLETE THIS PART AND PART 3.

(1) Write the names of everyone in your household.
(2) Write the amount of income received last month for each household member (the amount before taxes or before anything else is taken out), and where it came from, such as earnings, welfare, pensions, and other income (refer to examples below for types of income to report). If any amount *last month* was more or less than usual, write that person's usual income.
(3) An adult household member reporting total household income must sign the form and include the **last four digits** of give his/her Social Security Number in **PART 3.**

Note to Center/Reviewer: If you are uncertain of how the family receives income (monthly, weekly, bi-weekly, annually) consider the income reported as the income for the month. If this is not workable, contact the family for clarification.

INCOME TO REPORT		
Earnings From Employment:	**Pensions/Retirement/Social Security:**	**Other Income:**
Wages/Salaries/Tips Strike Benefits Unemployment Compensation Worker's Compensation Net income from self-owned business or farm	Pensions, Supplemental Security Income Cash withdrawn from savings, Retirement Income Veteran's Payments Social Security Regular contributions from persons not living in the household	Disability Benefits Interest/Dividends Income from Estate/Trusts/Investments Net Royalties/Annuities Net Rental Income Any Other Income
Welfare/Child Support/Alimony:	**Military Household:**	**Foster Child's Income:**
Public Assistance Payments Welfare Payments Alimony/Child Support	All cash income, including military housing/ uniform allowances Does not include "in-kind" benefits NOT paid in cash (base housing, medical care, clothing, food, etc.)	ONLY funds from welfare agency identified by category for **personal use** of child (clothing, school fees, etc.), funds from child's family for personal use, and earnings from other sources (i.e., occasional or part-time employment) need to be included. **DO NOT** count funds from welfare agency for shelter, care, etc.

PART 3: CERTIFICATION - SIGNATURE AND SOCIAL SECURITY NUMBER: **ALL HOUSEHOLDS** COMPLETE THIS PART.

(1) All Income Eligibility Forms must have the signature of an adult household member.
(2) The adult household member who signs the form must include the **last four digits** of his/her Social Security Number **IF** the participant is eligible for "free or reduced" based on household income. Section 9 of the National School Lunch Act requires that unless the participant's SNAP (food stamp), TANF case number is provided or the participant is a foster child or homeless, you must include the last four digits of the Social Security Number of the household member signing the statement, or an indication that the household member signing the statement does not possess a Social Security Number. Provision of the last 4 digits of the Social Security Number is not mandatory, but if a Social Security Number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved. The Social Security Number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a SNAP or TANF office to determine current certification for receipt of SNAP or TANF benefits, contacting the State Employment Security Office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal action. If he/she does not have a Social Security Number, check the "I do not have a Social Security Number" box.
(3) If you listed a **SNAP** or **TANF** case number or the participant is a **Head Start, ECAP**, **Foster** or **Homeless** child, the last four digits of a Social Security Number **is not** needed.

SPONSOR USE ONLY – Eligibility Determination: **To be completed by Child Care Representatives ONLY.** (1) Complete total household income and size section. Compare total Income to *Household Income Eligibility Guidelines*. When household incomes are listed from different pay persons, you must convert all income to yearly income using the conversion table listed. Follow other instruction as indicated. (2) The review/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.

PRIVACY ACT STATEMENT: *The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the application. The Social Security Number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP, i.e., Food Stamp), Temporary Assistance for Needy Families (TANF) Program or when you indicate that the adult household member signing the application does not have a Social Security Number. We will use your information to determine if the participant is eligible for free or reduced price meals, and for administration and enforcement of the Program.*

NON-DISCRIMINATION STATEMENT: *In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call toll free (866) 632-9992 (Voice). TDD users can contact USDA through local relay or the Federal Relay at (800) 877-8339 (TDD) or (866) 377-8642 (relay voice users). USDA is an equal opportunity provider and employer.*

CHILD AND ADULT CARE FOOD PROGRAM
ENROLLMENT FORM

Day Care Provider/Center

Name: _____
Provider/Center's Name

Address: _____ **Telephone:** _____
Address

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: Yes No**

Arrival Time: _____ **AM/PM** (Circle) **Departure time:** _____ **AM/PM** (Circle)

***Normal* days of week Participant/s is/are in care: Mon Tues Wed Thu Fri Sat Sun**
(Circle all that apply)

Meals eaten at Providers/Center: (Circle all that apply. CACFP provides reimbursement for up to 2 approved meals and one snack per day/participant):

Breakfast AM Snack Lunch PM Snack Supper Evening Snack

Parent/Guardian/Participant:

Name _____ **Telephone:** _____
Contact phone #

Address: _____
City State Zip Code

Signature: _____ _____
Parent/Guardian/Participant Date

Sponsor Use Only

_____ _____
Determining Official **Date**

Participant/s Exit Date: _____

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. (Not all prohibited bases apply to all programs.) To file a complaint of discrimination, write USDA, Directs, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SE Washington, De 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer. Revised: 09/25/12

CACFP Time and Attendance Log Worksheet

Administrative and other staff performing CACFP and non-CACFP duties must complete this form.

INSTRUCTIONS: This worksheet must be completed for staff performing Child and Adult Care Food Program duties if any CACFP funds are used for salaries. Indicate the total number of hours worked per day, the total number of non-CACFP hours worked per day, then the number of hours spent on activities related to the CACFP (i.e., food service labor and/or administrative [Admin] labor duties). Examples of CACFP activities include, but are not limited to: menu planning, grocery shopping, cooking and serving meals, clean-up after meals, record keeping, attending inservices related to nutrition and food safety, maintaining inventory, etc. Additional instructions on back.

Employee Name (please print legibly) _____ Month/Year:_____

(A) Day of Month	(B) Total Day Care Hours Worked*	(C) Non-CACFP Hours	(D) CACFP Hours		(A) Day of Month	(B) Total Day Care Hours Worked*	(C) Non-CACFP Hours	(D) CACFP Hours	
			(D1) Food Service Labor	(D2) Admin. Labor				(D1) Food Service Labor	(D2) Admin. Labor
1					17				
2					18				
3					19				
4					20				
5					21				
6					22				
7					23				
8					24				
9					25				
10					26				
11					27				
12					28				
13					29				
14					30				
15					31				
16					TOTAL				

*Employee time cards must be available to validate total hours worked.

I certify that this is an accurate record of the number of hours on the Child and Adult Care Food Program.

Employee Name (please print legibly) Employee's Signature Date

Office Use Only: TO BE COMPLETED BY CENTER DIRECTOR/CACFP AUTHORIZED REPRESENTATIVE

A. **(HOURLY PAID STAFF)**

Total hours worked on CACFP _____ x $_____ (hourly wage) = $_____(Total CACFP salary)

B. **(SALARIED STAFF)**

Total hours worked on CACFP _____ ÷ Total hours worked _____ = _____%

Total Salary for month $_____ x _____% = $_____ (Total CACFP salary)

I certify that payroll records are on file that verify the total wages as listed above.

Signature of Center Director/Authorized Representative _____ Date_____

Time and Attendance/Time Distribution Instructions

1. Each person claimed for Child and Adult Care Food Program (CACFP) operations must complete their own form.

2. Report the actual time distribution of CACFP and non-CACFP activities after the fact. (Refer to the list below for food service labor and administrative labor duties.*)

3. Indicate the total hours worked; the total non-CACFP hours worked; and the CACFP hours (i.e., hours spent on CACFP duties food service labor [FSL) and administrative labor).

(a) The total of non-CACFP hours (column C) and CACFP Hours in column D [D1 + D2] should equal the total day care hours worked (column B).

(b) Example: On January 2, 2012, I worked a total of 8 day care hours; 2 of the hours were CACFP related (clean-up after meal service = FSL); the calculation ->[8 - 2 = 6 (non-CACFP hours worked)]. Go to Column A, to the second day of the month, enter 8 in Column B, enter 6 in Column C, enter 2 in column D1.

4. Total Columns B, C, D1 and D2 at the end of the month. Add columns D1 and D2 at the end of each month for the total number of CACFP hours worked. Supervisors only should proceed with the **Office Use Only** section. Follow instructions indicated.

5. The employee will sign the monthly report form.

6. The supervisor will sign the monthly report form.

Definition:

***Food Service Labor Cost** is considered time spent solely for the purpose of carrying out CACFP related duties and responsibilities. Cooks and employees, whose duties are directly related to the meal preparation, planning and service fall in this category.

> **Duties**: meal planning and purchasing; meal preparation, serving, and clean-up of program meals; supervision of day to day food service operations including supervision of children during meal service; recording meal attendance (point-of-service meal counts).

***Administrative Labor** includes salaries and benefits of administrative personnel (secretaries, accountants and others) necessary to support program administrative activities allowable.

> **Duties**: planning, organizing and managing the food service operation; completing the CACFP application; compiling daily records to complete the monthly reimbursement claim; training; preparing monthly reimbursement claim; conducting CACFP site review (monitoring).

NOTE: Administrative labor is chargeable at a rate of up to three (3) hours per day per person, not to exceed fifteen (15) hours per week per person.

CHILD AND ADULT CARE FOOD PROGRAM
TRAINING DOCUMENTATION FORM

Center Name: _____
(Name of Institution)

Date of Training Session: _____

Time of Training Session: _____

Name & Title of Trainer: _____

Topics Discussed:
(Check the box for each topic discussed during the session.)

Meal Pattern Requirements	( )
Menus	( )
Meal Count Procedures	( )
Enrollment Statements	( )
Income Eligibility Classifications	( )
Recordkeeping Procedures	( )
Itemized Receipts	( )
Time & Attendance Logs	( )
Training Requirements	( )
Monitoring Requirements	( )
Claim Completion Procedure	( )
Daily Attendance Records	( )
Other: _____	( )
_____	( )

ATTENDEES
(Each Person Attending Must Sign In)

Name	Title or Position

Use additional sheets if necessary.

INFANT 0- 3 MONTHS MENU

Provider _____ **Infant Name**_____

Formula Provider Offers_____ **Date of Birth** _____

TO BE COMPLETED BY PARENT

Providers in the CACFP are required to offer at least 1 brand of infant formula and offer solid infant foods. I understand that I am not required to bring iron fortified infant formula or infant food that I purchase, however I may want to choose to bring my own infant formula/breast milk or my own infant food.

Check all that apply: ____ I accept formula provider offers **____ I bring in breast milk**

____ I bring in formula (please name formula) _____

Parent's Signature_____ **Date**_____

DATE						
MEAL	**MENU ITEM**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
BREAKFAST	4-6 OZ FORMULA/ BREAST MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
LUNCH/SUPPER	4-6 OZ FORMULA/ BREAST MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
AM/PM SNACK	4-6 OZ FORMULA/ BREAST MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK

DATE						
MEAL	**MENU ITEM**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
BREAKFAST	4-6 OZ FORMULA/ BREAST MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
LUNCH/SUPPER	4-6 OZ FORMULA/ BREAST MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
AM/PM SNACK	4-6 OZ FORMULA/ BREAST MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK

INFANT MENU 0- 3 MONTHS

Provider Name________________________________ **Infant Name**________________________________ **DOB**________________________

DATE						
MEAL	**MENU ITEM**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
BREAKFAST	4-6 OZ FORM/B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	LETTER					
LUNCH/SUPPER	4-6 OZ FORM/B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	LETTER					
AM/PM SNACK	4-6 OZ FORM/B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	LETTER					

DATE						
MEAL	**MENU ITEM**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
BREAKFAST	4-6 OZ FORM/B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	LETTER					
LUNCH/SUPPER	4-6 OZ FORM/B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	LETTER					
AM/PM SNACK	4-6 OZ FORM/B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	LETTER					

DATE						
MEAL	**MENU ITEM**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
BREAKFAST	4-6 OZ FORM/B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	LETTER					
LUNCH/SUPPER	4-6 OZ FORM/B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	LETTER					
AM/PM SNACK	4-6 OZ FORM/B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	LETTER					

INFANT 4-7 MONTHS MENU

Provider _____ **Infant Name**_____

Formula Provider Offers _____ **Date of Birth** _____

TO BE COMPLETED BY PARENT

Providers in the CACFP are required to offer at least 1 brand of infant formula and offer solid infant foods. I understand that I am not required to bring iron fortified infant formula or infant food that I purchase, however I may want to choose to bring my own infant formula/breast milk or my own infant food.

Check all that apply: ____**I accept formula provider offers**

____ **I bring in breast milk**

____ **I bring in formula (please name formula)** _____

____ **I accept provider's infant food when developmentally ready**

____ **I bring in infant food when developmentally ready**

CEREAL: RICE OATMEAL BARLEY

FRUIT: APPLESAUCE BANANAS PEACHES PEARS PRUNES

VEG: CARROTS GREEN BEANS SWEET POTATOES SQUASH PEAS

Parent's Signature_____ **Date**_____

DATE						
MEAL	**MENU ITEM**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
BREAKFAST	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0-3 T INFANT CEREAL					
LUNCH/SUPPER	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0-3 T INFANT CEREAL					
	0-3 T FRUIT OR VEG.					
AM/PM SNACK	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK

INFANT MENU 4-7 MONTHS

Provider Name_____ **Infant Name**_____ **DOB**_____

DATE						
MEAL	**MENU ITEM**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
BREAKFAST	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0-3 T INFANT CEREAL					
	LETTER					
LUNCH/SUPPER	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0-3 T INFANT CEREAL					
	0-3 T FRUIT OR VEG.					
	LETTER					
AM/PM SNACK	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	LETTER					

DATE						
MEAL	**MENU ITEM**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
BREAKFAST	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0-3 T INFANT CEREAL					
	LETTER					
LUNCH/SUPPER	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0-3 T INFANT CEREAL					
	0-3 T FRUIT OR VEG.					
	LETTER					
AM/PM SNACK	4-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	LETTER					

children FAMILIES first

Provider _____ **Infant Name**_____

Formula Provider Offers _____ **Date of Birth** _____

TO BE COMPLETED BY PARENT

Providers in the CACFP are required to offer at least 1 brand of infant formula and offer solid infant foods. I understand that I am not required to bring iron fortified infant formula or infant food that I purchase, however I may want to choose to bring my own infant formula/breast milk or my own infant food.

Check all that apply:

____ **I accept formula provider offers**

____ **I bring in breast milk**

____ **I bring in formula (please name the formula)** _____

____ **I accept provider's infant solid foods when developmentally ready**

____ **I bring in infant solid foods when developmentally ready**

____ **I give permission for table foods when developmentally ready**

____ **I bring in table food items** ____ **I accept provider's table food items**

CIRCLE THE FOODS THAT YOU HAVE INTRODUCED TO YOUR INFANT AND WILL ALLOW US TO SERVE YOUR INFANT:

CEREAL: RICE OATMEAL BARLEY BROWN RICE WHOLE WHEAT (No Fruit) **MEAT: BEEF CHICKEN TURKEY LAMB VEAL**

VEG: CARROTS GREEN BEANS SWEET POTATOES SQUASH PEAS **FRUIT: APPLESAUCE BANANAS PEACHES PEARS PRUNES OTHER**_____

SNACKS: WG CRACKERS (NAME) WG BREAD **Parent's Signature**_____ **Date**_____

DATE						
MEAL	**MENU ITEM**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
BREAKFAST	6-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	1-4 T. INF. CEREAL					
	1-4 T FRUIT **&/OR** VEG.					
LUNCH/SUPPER	6-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	2-4 T. INF. CEREAL **OR** 1-4 T. MEAT/MEAT ALT.					
	1-4 T. FRUIT **&/OR** VEG					
AM/PM SNACK	2-4 OZ. FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0- ½ SLICE BREAD **OR** 0-2 CRACKERS					

INFANT MENU 8-11 MONTHS

Provider Name_____ **Infant Name**_____ **DOB**_____

DATE						
MEAL	**MENU ITEM**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
BREAKFAST	6-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	1-4 T. INF. CEREAL					
	1-4 T FRUIT **&/OR** VEG.					
	LETTER					
LUNCH/SUPPER	6-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	2-4 T. INF. CEREAL **OR** 1-4 T. MEAT/MEAT ALT.					
	1-4 T. FRUIT **&/OR** VEG					
	LETTER					
AM/PM SNACK	2-4 OZ. FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0- ½ SLICE BREAD **OR** 0-2 CRACKERS					
	LETTER					

DATE						
MEAL	**MENU ITEM**	**MONDAY**	**TUESDAY**	**WEDNESDAY**	**THURSDAY**	**FRIDAY**
BREAKFAST	6-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	1-4 T. INF. CEREAL					
	1-4 T FRUIT **&/OR** VEG.					
	LETTER					
LUNCH/SUPPER	6-8 OZ FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	2-4 T. INF. CEREAL **OR** 1-4 T. MEAT/MEAT ALT.					
	1-4 T. FRUIT **&/OR** VEG					
	LETTER					
AM/PM SNACK	2-4 OZ. FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK	FORM/ B MILK
	0- ½ SLICE BREAD **OR** 0-2 CRACKERS					
	LETTER					

Center's Name: _____ **Week Beginning:** _____

Meal Pattern	Date:	Date:	Date:	Date:	Date:
Breakfast: Milk	Milk	Milk	Milk	Milk	Milk
Juice/Fruit/Veg.					
Bread/Cereal					
Other					
AM Snack: * (select 2 items) Milk					
Meat/Meat Alt.					
Juice/Fruit/Veg.					
Bread/Cereal					
Lunch: Milk	Milk	Milk	Milk	Milk	Milk
Meat/Meat Alt.					
Veg. or Fruit					
Veg. or Fruit					
Bread					
PM Snack: * (select 2 items) Milk					
Meat/Meat Alt.					
Juice/Fruit/Veg.					
Bread/Cereal					
Supper: Milk	Milk	Milk	Milk	Milk	Milk
Meat/Meat Alt.					
Veg. or Fruit					
Veg. or Fruit					
Bread					

*Snack only…. Items *must be* from two (2) different 'food component' groups. In addition, if Milk is selected for one snack component - no Fruit/Veg. juice is allowed.