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CHILD AND ADULT CARE FOOD PROGRAM FORMS FOR FAMILY CHILD CARE HOMES

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_____

CHILD AND ADULT CARE FOOD PROGRAM ENROLLMENT FORM

Provider Name _____

Address _____

_____ **____ NEW**

Phone _____ **____ UPDATE/RENEWAL**

Dear Parent/Guardian:
By completion of this document, you are enrolling your child in the Child and Adult Care Food Program that is Sponsored by Children & Families First. The CACFP is a federally funded program under the USDA which extends the National School Lunch Program to children in family child care homes. Your provider has chosen to participate in this program, and agrees to follow the guidelines and regulations mandated by the program. In return, your provider is reimbursed a meal rate to help with the cost of serving nutritious meals to all children in her/his care.

Participating Child _____

Enrollment Date _____/_____/_____

Date of Birth_____/_____/_____ **Age** _____ **Sex** M F

Normal Hours in Care: from _____ to _____

Normal Days of Care: M T W T F Sat Sun

Normal Meals Expected served daily in Care:

Breakfast Am Snack Lunch Pm Snack Supper Eve Snack

Name of School/PS/HS_____

Leaves for school _____Return from school _____

Racial/Ethnic Data:
Please mark one of the following ethnic identities:
___ Hispanic or Latino ___ Not Hispanic or Latino

Please mark one or more of the following racial identities:
___ American Indian or Alaska Native ___Native Hawaiian or Other Pacific Islander ___ Asian ___ Black or African American ___ White

Race and ethnicity information is requested by the USDA to assure compliance with Title IV. Collection is strictly for statistical reporting requirements.

Participating Child _____

Enrollment Date _____/_____/_____

Date of Birth_____/_____/_____ **Age** _____ **Sex** M F

Normal Hours in Care: from _____ to _____

Normal Days of Care: M T W T F Sat Sun

Normal Meals Expected served daily in Care:

Breakfast Am Snack Lunch Pm Snack Supper Eve Snack

Name of School/PS/HS_____

Leaves for school _____Return from school _____

Racial/Ethnic Data:
Please mark one of the following ethnic identities:
___ Hispanic or Latino ___ Not Hispanic or Latino

Please mark one or more of the following racial identities:
___ American Indian or Alaska Native ___Native Hawaiian or Other Pacific Islander ___ Asian ___ Black or African American ___ White

Race and ethnicity information is requested by the USDA to assure compliance with Title IV. Collection is strictly for statistical reporting requirements.

FORMULA OPTION FOR INFANTS

(fill in only if you have an infant under 12 months)

To meet CACFP requirements, your provider offers the formula _____iron fortified formula to infants in his/her care through your infants first year. You as the parent, may choose to accept this formula, or you may choose to supply another type of iron fortified formula and/or solid foods until your infant's first birthday. Check only the options that apply:

___ parent accepts formula provider offers

___ parent supplies breast milk

___ parent supplies formula (please list type) _____

___ parent accepts provider's food when developmentally ready

___ parent supplies food when developmentally ready

I understand that 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 information which explains the goals of the Child and Adult Care Food Program. I understand that I may be contacted by my providers sponsor, Children & Families First, regarding meals she/he has claimed. If I need to be contacted by phone/mail to update and/or verify this information my contact information is:

Parent/Guardian Contacts Home Phone_____ Work Phone _____ Cell _____

Address_____
(STREET, APT # , CITY, STATE, ZIP)

Parent/Guardian Name (print) _____

Parent/Guardain Signature _____ 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 or retaliation. If you require this information in alternative format (Braille, Lg. Print, Audio Tape, etc.), contact the USDA's TARGET Center @ 202-720-2600. (voice or TDD). If you require information about this program, activity or facility in a language other than English, contact the USDA Agency responsible for the program or activity, or any USDA office. To file a complaint alleging discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call, toll free, 866-632-9992 (V). TDD users can contact USDA through local relay or the Federal Relay @ 800-877-8339 (TDD) or 866-377-8642 (relay voice users). USDA is an equal opportunity provider and employer.

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					

ATTENDANCE / MONTHLY MEAL COUNT RECORD

Provider's Name_____

Address_____

E I #_____

Telephone #_____

Month and Year_____

Licensing Level_____

Infants below 12 mos._____

of provider's own children **not** attending school_____

DATE	ATTENDANCE DAILY	TOTAL	BREAKFAST	AM SNACK	LUNCH	PM SNACK	SUPPER	EVE SNACK
01								
02								
03								
04								
05								
06								
07								
08								
09								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
	TOTAL							

	*	AGE
A_____		
B_____		
C_____		
D_____		
E_____		
F_____		
G_____		
H_____		
I _____		
J_____		
K_____		
L_____		
M_____		
N_____		

* Please Indicate: N= new child
W= withdrawn and date
HS= Head Start
K= Kindergarten

CERTIFICATION

I certify that the information submitted is accurate in all respects, and that I understand this information is given in connection with the receipt of Federal Funds, and that deliberate misrepresentation may result in State or Federal prosecution.

SIGNATURE_____ **MONTH**_____

Tier	Days	Child	Attend	Break	AM	Lunch	PM	Sup	EVE	Amount	Initial	Tier
1												
2												

For Official Use Only

Rev Aug 2009

PROVIDER'S NAME__________________________________ WEEK BEGINNING______________________

MEAL PATTERN	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Breakfast: Milk Juice/fruit/veg Bread/cereal Other	Milk	Milk	Milk	Milk	Milk
Children Served/TOTAL					
A.M Snack: (select 2) Milk Meat/Meat alt. Juice/fruit/veg. Bread/cereal					
Children Served/TOTAL					
Lunch: Milk Meat/Meat Alt. Veg. or fruit Veg. or fruit Bread	Milk	Milk	Milk	Milk	Milk
Children Served/TOTAL					
P.M. Snack: (select 2) Milk Meat/Meat alt. Juice/fruit/veg. Bread/cereal					
Children Served/TOTAL					
Supper: Milk Meat/Meat Alt. Veg. or fruit Veg. or fruit Bread	Milk	Milk	Milk	Milk	Milk
Children Served/TOTAL					