

Child Care & Nutrition, Inc. (CCNI) Child Enrollment Form

PO Box 138 • Ivanhoe, MN 56142 • 800-634-3359 • www.childcarenutrition.com

Provider Name: _____

Provider ID: _____

Dear Parents: Your child care provider participates in the United States Department of Agriculture (USDA) Child & Adult Care Food Program (CACFP). This child care home receives Federal cash assistance to help serve healthy meals to your children. Meals served here must meet nutrition requirements established by USDA's CACFP. In order to participate your provider has agreed to follow the USDA guidelines. In an effort to assess that these requirements are being met, the USDA and CACFP require providers to annually collect the information on this form. Please complete the form to the best of your ability. **Child Care Nutrition, Inc. is an equal opportunity provider and employer. See back for full non-discrimination statement, race/ethnicity information, and WIC Information.**

CHILD'S FIRST NAME	LAST NAME	BIRTHDATE	BEGINNING DATE OF CARE	ETHNICITY
				<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
HOURS IN CARE		DAYS IN CARE	MEALS SERVED	RACE (Check all that apply)
Indicate the usual hours your child is in care Time in: _____ Time out: _____ Time in: _____ Time out: _____ Example: 7:30AM – 5:00PM or for a split schedule 7:00AM – 8:00AM & 3:30 PM – 5:00 PM Times may vary <input type="checkbox"/> More than 24hours consecutively <input type="checkbox"/>		M T W T H F S S circle the days child is usually in care days may vary <input type="checkbox"/> drop in only <input type="checkbox"/> Parent works varying shifts <input type="checkbox"/>	<input type="checkbox"/> Breakfast <input type="checkbox"/> PM Snack <input type="checkbox"/> AM Snack <input type="checkbox"/> Supper <input type="checkbox"/> Lunch <input type="checkbox"/> Eve Snack <input type="checkbox"/> This child has dietary substitutions or omissions	<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander
SUMMER SCHEDULE (if different from usual days and hours)	Time in: _____ Time out: _____ M T W T H F S S	days may vary <input type="checkbox"/> drop in only <input type="checkbox"/>	RELATIONSHIP TO PROVIDER	FOSTER CHILD
			<input type="checkbox"/> Own Child <input type="checkbox"/> Co-Licensed Child	Yes <input type="checkbox"/> No <input type="checkbox"/>

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All infants MUST be offered at least one type of iron-fortified infant formula by the childcare provider. Provider supplies: _____

I want my provider to supply the above named iron-fortified infant formula for my infant -OR- I will supply breast milk for my infant

I understand my provider has offered the formula indicated above, but I am choosing to supply: _____

I want my provider to supply all solid foods for my infant when my infant is developmentally ready for them, as required by the CACFP.

I will supply the following solid foods when my infant is developmentally ready for them: _____

Parent's Signature _____ Date Signed _____

Parent's Name: _____
Please Print

Phone: _____
Include area code

Mailing Address: _____

Email Address: _____

City: _____ State: _____

Zip: _____

White – Office Copy

Yellow – Provider Copy

Pink – Parent Copy

For Office Use Only:
Valid Dates of Enrollment (child 1): _____ to _____ Valid Dates of Enrollment: (child 2) _____ to _____

Valid Dates of Enrollment (child 3): _____ to _____ Processed By: _____

Not valid for claims prior to (Month/Year) _____ Renewal Gap in Enrollment Picked up at Home Visit (Rep Initial & Date) _____

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Please check the option, or fill in the spaces to best describe your school aged child's school information this year

A child is considered "School Aged" on their 5th birthday – if your child attends pre-school please complete the information below as well.

Child's Full Name:			DOB:	
My Child Attends: <input type="checkbox"/> a Public School <input type="checkbox"/> a Private School <input type="checkbox"/> is Home Schooled <input type="checkbox"/> Other: _____	School Schedule: <input type="checkbox"/> School week is Monday thru Friday <input type="checkbox"/> School week is Tuesday thru Friday <input type="checkbox"/> School week is Monday thru Thursday <input type="checkbox"/> Other: _____	Kindergarten Schedule: <input type="checkbox"/> Attends full day, every day <input type="checkbox"/> Attends ½ day, every day <input type="checkbox"/> Attends full day, every other day <input type="checkbox"/> Held back and not attending school this year <input type="checkbox"/> Other: _____	School District:	
			School Name:	
			Grade Level:	

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			Grade Level:	

Please use the space below to include any questions, comments, concerns, additional notes, special diet information, special schedule information, etc., and whether or not you'd like to be contacted with a response to any of the information listed.

If your child follows a special diet, your provider may be required to obtain written documentation from a medical professional.

**The Civil Rights Ethnicity and Race information request on the front side of this form is voluntary and is requested to determine compliance with civil rights laws. If you choose not to complete this section, a visual identification will be made by the provider or CCNI staff.*

WIC INFORMATION: More people are eligible for WIC (Women's Infants & Children) Program than you think! WIC serves pregnant, postpartum and breastfeeding women; infants and children to age 5 and many working families. WIC participants receive healthy foods like milk, cheese, cereal and eggs; breast feeding information and support; referrals to health and social services, nutrition and health information and infants, who are partially or not breastfed may receive iron-fortified infant formula. CALL FOR A WIC CLINIC NEAR YOU 1-800-WIC-4030 or go to <http://www.health.state.mn.us/divs/fh/wic>

State Administration Contact Information: MDE • Food & Nutrition Service • 1500 Highway 36 West Roseville, MN 55113 • 1-800-366-8922 • mde.fns@state.mn.us

Nondiscrimination Statement

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the [USDA Program Discrimination Complaint Form](http://www.ascr.usda.gov/complaint_filing_cust.html), (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) Mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; (2) Fax: (202) 690-7442; or (3) Email: program.intake@usda.gov. This institution is an equal opportunity provider.