

CACFP CHILD ENROLLMENT FORM

Sanford Children's CHILD Services
 Children's Family Day Care Network
 5015 S. Western Ave., Suite 120, Sioux Falls, SD 57108
 (605) 312-8390



Provider Name: _____

Please complete all the information below for each child enrolled in care and sign the document.

| Child Information | Normal Day/Hours in Care <small>Circle All that Apply</small> | Meals Normally Eaten at Facility <small>Circle All that Apply</small> | Provider Fills Out |
|---|--|--|---|
| 1. Full Name: _____ 2. Date of Birth: _____ 3. Ethnicity: <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Hispanic/Latino 4. Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White 5. List Special Diet/Needs: _____ | 6. Normal Days in Care: Mon Tues Wed Thur Fri <input type="checkbox"/> Check if day/hours vary 7. Normal Hours in Care: _____ to _____ | 8. Meals Normally Eaten at Facility: Breakfast Am Snack Lunch PM Snack | Enrollment Date: _____ Update Date: _____ Dismissal Date: _____ |
| 1. Full Name: _____ 2. Date of Birth: _____ 3. Ethnicity: <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Hispanic/Latino 4. Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White 5. List Special Diet/Needs: _____ | 6. Normal Days in Care: Mon Tues Wed Thur Fri <input type="checkbox"/> Check if day/hours vary 7. Normal Hours in Care: _____ to _____ | 8. Meals Normally Eaten at Facility: Breakfast Am Snack Lunch PM Snack | Enrollment Date: _____ Update Date: _____ Dismissal Date: _____ |
| 1. Full Name: _____ 2. Date of Birth: _____ 3. Ethnicity: <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Hispanic/Latino 4. Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White 5. List Special Diet/Needs: _____ | 6. Normal Days in Care: Mon Tues Wed Thur Fri <input type="checkbox"/> Check if day/hours vary 7. Normal Hours in Care: _____ to _____ | 8. Meals Normally Eaten at Facility: Breakfast Am Snack Lunch PM Snack | Enrollment Date: _____ Update Date: _____ Dismissal Date: _____ |

Parents/Guardian's Name (Print) : _____ Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mother's Employer: _____ Phone: _____ Cell: _____

Father's Employer: _____ Phone: _____ Cell: _____

Parent's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

Office Use:
 Date Entered: _____
 Staff Initials: _____

NONDISCRIMINATION STATEMENT

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To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (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.

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