North Carolina Department of Health and Human Services Division of Child and Family Well-Being, Community Nutrition Services Section Child and Adult Care Food Program



Infant and Child Enrollment Form

NAME:	FACILITYNAME:			AGREEMENT#:			
Program (CACFP). CA	receives funding from a ACFP needs proof of enr n your family enrolled at	ollment for a t this center/p	ll infants and child program. Be sure	ture (USDA) Child and Ad dren. Please complete the to sign and date in the sp	table below for	each	
Infant/Child's	Infant/Child's	Date of	Normal/Typical	Normal/Typical Days of	Meals Normally Eaten		
First Name	Last Name	Birth	Hours of Care	Care (Circle all that apply) M T W Th F Sat Sun	(Circle all that		
			to	M T W Th F Sat Sun	B AM L PM	S LPM	
			to	M T W Th F Sat Sun	B AM L PM	S LPM	
			to	M T W Th F Sat Sun	B AM L PM	S LPM	
			to	M T W Th F Sat Sun	B AM L PM	S LPM	
(M-Monday; Meals Normally Eate	: T-Tuesday; W-Wednes en – Circle the meals eac	day; Th- Thur ch infant/chilo	sday; F-Friday; Sa I usually eats at th	ly in attendance at the far t-Saturday; Sun-Sunday) ne facility. 1-Late PM/Evening Snack)	·		
Parent/Guardian Signature:				Date:			
Print Name:							
Address:							
City:			_State:Zip	Code:			
Home Telephone Nu	mber: (<u>)</u>	V	Vork Telephone N	lumber: ()			
For Facility/Provider Use Only: Signature of Facility Representative/Provider:							
Date each infant/child with	drew:						
For State Use Only: Complete:	Incomplete	Reason:		Verified by:	Date:		

This institution is an equal opportunity provider.