

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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- (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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