_____New Enrollment _____Renewal/Update

OREGON CHILD DEVELOPMENT COALITION
1345 Center Drive, #F
Medford, Or. 97501
541.770.5893 Fax 971.224.1355

FDCH CHILD ENROLLMENT FORM

____
First and Last Name of FDCH Provider

TO BE COMPLETED BY PARENT/GUARDIAN ONLY

The CACFP reimburses providers for serving nutritious, well-balanced meals and snacks to children in care. Complete the following chart for all children in care. Sign, date, and submit it to the provider. Use additional forms, as needed. Parents/guardians of all infants must complete the Infant Formula Selection section.

Children's Names	Child's Birth-date	Normal Hours in Care: Enter the time your child usually *arrives* each day.	Normal Hours in Care: Enter the time your child usually *leaves* each day.	Normal Meals and Normal Days in Care Type of Care. Please circle Full Time Part Time Days/Time vary Drop in care
Last:				Normal Meals While In Care: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack
First		Time ☐ AM ☐ PM	Time ☐ AM ☐ PM	Normal Days of the Week in Attendance: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun
Last				Normal Meals While In Care: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack
First		Time ☐ AM ☐ PM	Time ☐ AM ☐ PM	Normal Days of the Week in Attendance: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun
Last				Normal Meals While In Care: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack
First		Time ☐ AM ☐ PM	Time ☐ AM ☐ PM	Normal Days of the Week in Attendance: ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun

INFANT FORMULA SELECTION: Complete if any child listed above is an infant under one year of age

This provider supplies ____________________ (list brand) iron fortified infant formula.

Check one:
☐ I accept the provider supplied formula
☐ I decline the provider supplied formula
I understand that by declining the provider supplied formula, I agree to provide breast milk or formula for my child. If I provide formula it must be on the approved formula list for the provider to be reimbursed for the meal.

_______________________________ Signature of Parent or Legal Guardian

_______________________________ Address

City ______________ State ________ Zip ________ Phone Number ______________

_______________________________ Printed Name

________ Start Date ________ Renewal Date

OCDC Please Initial

Date Entered

RACIAL OR ETHNIC GROUP (OPTIONAL)

Mark one ethnic identity:

_______ Hispanic or Lation
_______ Not Hispanic or Lation

Mark one or more racial identities:

_______ Asian
_______ American Indian & Alaskan Native
_______ Native Hawaiian or Other Pacific Islander
_______ Black or African American
_______ White, not of Hispanic Origin
_______ Other

OCDC is an equal opportunity provider