____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:		______ Time	______ Time	Normal Meals While In Care: Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First		☐ AM ☐ PM	☐ AM ☐ PM	Normal Days of the Week in Attendance: Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last		______ Time	______ Time	Normal Meals While In Care: Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First		☐ AM ☐ PM	☐ AM ☐ PM	Normal Days of the Week in Attendance: Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat ☐ Sun ☐
Last		______ Time	______ Time	Normal Meals While In Care: Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
First		☐ AM ☐ PM	☐ 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