**Massachusetts Department of Elementary and Secondary Education (DESE)**

**Office for Food and Nutrition Programs**

**Child Enrollment Documentation Requirement**

**Child and Adult Care Food Program – Family Day Care**

Sponsoring Organizations of Family Day Care Providers that participate in the Child and Adult Care Food Program (CACFP) are required to annually collect enrollment information from parents and guardians.

Documentation of enrollment must include:

* Each enrolled child’s normal days and hours in care and the meal services in which each child normally participates
* Signature of parent or guardian
* Annual updating of the information.

7 CFR 226.15(e)(2) & 226.18(e)

To document enrollment information, Sponsoring Organizations (SO) may use the attached CACFP Enrollment Forms or adapt their own form. An adapted form must incorporate the same questions and their intent from the DESE Child Enrollment Form. As per DESE Family Day Care Policy, Sponsors electing to revise the enrollment form must submit a copy to DESE for review and approval prior to use and distribution.

The parent/guardian must complete the form in full with current information, sign, and date the form. The provider must also complete an enrollment form for their own child(ren) being claimed for reimbursement. Providers must retain a copy of each enrollment form provided by the SO.

Sponsors must ensure that providers offering substitute care have an enrollment form on file for each participant claimed for reimbursement and enrolled in the home within twenty-four (24) hours of care.

Providers may not claim reimbursement for any participant without a parent/guardian signed enrollment form (new or renewal) on file. Each child enrollment form is effective for a maximum of one year.

Sponsors must perform edit checks for clerical accuracy confirming data entered on all child enrollment forms. Sponsors electing to use computerized renewal sheets must ensure that the form includes the participant’s name, date of birth, days of attendance, regular hours of attendance, meals served in care, and if applicable; the type of iron fortified infant formula offered by the Provider and school attendance information, as well as a place for the parent/guardian contact information and signature.

If you have any question about the requirement for collection of enrollment information, please contact DESE Special Nutrition Services at 781-338-6480 or email nutrition@doe.mass.edu.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA’s TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf>, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant’s name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or
2. **fax:**
(833) 256-1665 or (202) 690-7442; or
3. **email:**
[program.intake@usda.gov](http://mailto:program.intake@usda.gov/)

 This institution is an equal opportunity provider.

Child Enrollment Form

 Child & Adult Care Food Program FY24

Dear Parent/Guardian:

Your child care center **MAGIC SEASONS\_(CCB)**\_ participates in the United States Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) administered by the Massachusetts Department of Elementary and Secondary Education.

Meals served must meet nutrition requirements established by USDA’s Child & Adult Care Food Program. In order to participate, your provider has agreed to follow the USDA guidelines. A medical statement from your doctor is necessary if your child cannot eat foods required by the CACFP.

In an effort to assess that these requirements are being met, the USDA and CACFP requires providers to annually collect the enrollment information listed below.

**Please complete the form and return it to your Family Day Care Provider. Part 1 and Part 3 need to be completed by all families or guardians. Part 2 is to be completed ONLY if enrolling an infant child (under the age of 12 months).**

**PART 1: CHILD ENROLLMENT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s First Name |  Last Name | Child’s Date of Birth & Age | Beginning Date of Child Care |
|  |  |  |  |
| Times Child Normally Attends For example 7:30 AM – 5 PM **✓ Box □ Schedule Varies** | Hours from:\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_ | Check the days your child normally attends | 🞎 Sunday 🞎 Monday🞎 Tuesday🞎 Wednesday🞎 Thursday🞎 Friday🞎 Saturday | Check the meals you request that your child receives while in care | 🞎 Breakfast 🞎 AM Snack🞎 Lunch🞎 PM Snack🞎 Supper🞎 Evening Snack |

|  |  |  |  |
| --- | --- | --- | --- |
| Child’s First Name |  Last Name | Child’s Date of Birth & Age | Beginning Date of Child Care |
|  |  |  |  |
| Times Child Normally AttendsFor example 7:30 AM – 5 PM **✓ Box □ Schedule Varies** | Hours from:\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_ | Check the days your child normally attends | 🞎 Sunday 🞎 Monday🞎 Tuesday🞎 Wednesday🞎 Thursday🞎 Friday🞎 Saturday | Check the meals you request that your child receives while in care | 🞎 Breakfast 🞎 AM Snack🞎 Lunch🞎 PM Snack🞎 Supper🞎 Evening Snack |
| Child’s First Name |  Last Name | Child’s Date of Birth & Age | Beginning Date of Child Care |
|  |  |  |  |
| Times Child Normally AttendsFor example 7:30 AM – 5 PM **✓ Box □ Schedule Varies** | Hours from:\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_ | Check the days your child normally attends | 🞎 Sunday 🞎 Monday🞎 Tuesday🞎 Wednesday🞎 Thursday🞎 Friday🞎 Saturday | Check the meals you request that your child receives while in care | 🞎 Breakfast 🞎 AM Snack🞎 Lunch🞎 PM Snack🞎 Supper🞎 Evening Snack |

|  |
| --- |
| If there are other children in care, please complete additional forms as needed. |

**FOR SPONSOR OFFICE USE ONLY**

Effective Date of this Enrollment Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fiscal Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The effective date can be made retroactive back to the first day the child participates In the CACFP as long as it occurs in the same month this form is received.

**PART 2: INFANT MEAL NOTIFICATION (Birth through 11 months) FY24**

Nutritious meals meeting the United States Department of Agriculture guidelines are served to all children enrolled in this program, including children under the age of 12 months. The provider must meet the meal component requirements based on age and developmental readiness outlined in the Infant Meal Pattern. **Parents/Guardians may supply not more than one required component per meal in the meal pattern (including breast milk or formula) in order for the meal to be reimbursable in CACFP.**

 **I understand that this Child Care Center has available the iron fortified formula \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for my infant while in care. (Name of Iron Fortified Infant Formula)**

 **To help provide the best nutritional care for your infant, please complete the following information.**

## PLEASE CHECK ONE OPTION (Breast Milk / Formula):

 I will supply expressed (pumped) breast milk for my infant child and/or breast feed at day care home. **OR**  I will supply formula for my infant child.

 I prefer to have the provider supply the formula offered.

## PLEASE CHECK ONE OPTION (Food Items):

##  I will supply all food items for my infant’s meals. I decline food items provided by the provider/center.

 I have elected to have the provider/center supply the formula and I wish to provide one food item. I will provide the following one creditable food item: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I would like provider/center to provide all food items for my infant’s meals.

**PART 3: PARENT OR GUARDIAN ACCEPTANCE AND SIGNATURE**

I have read this child enrollment form and request that my child receive the above Child and Adult Care Food Program benefits. I have received a copy of this completed form.

|  |  |
| --- | --- |
|  Parent’s Signature | Date Signed (form must be completed annually) |
| Parent’s Name: |  | Home Phone: |
|  | Please Print |  |  |
| Mailing Address: |  | Work Phone: |  |
| City, State, Zip: |  |  Cell Phone:  |  |

CIVIL RIGHTS: This information is voluntary and will not affect your children’s eligibility. Please indicate the ethnic and racial identity of your children by checking a box in each of the categories. This information is being collected to assure that everyone receives CACFP benefits on a fair basis.
1. **Ethnic Identity** □ HISPANIC OR LATINO □ NOT HISPANIC OR LATINO.
2. **Racial Identity** □ AMERICAN INDIAN OR ALASKA NATIVE □ ASIAN □ BLACK OR AFRICAN AMERICAN

 □ NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER □ WHITE.

**For questions please contact: CCB, Kelly M. Poirot, 413.664.3256 ext.119**

 This institution is an equal opportunity provider.