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

INSTITUTION NAME: MCAS Cherry Point CYP FACILITY NAME: 4298, 4629, 4859, CTH 4415 AGREEMENT#: 7177

Dear Parent/Guardian,

This center/program receives funding from the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). CACFP needs proof of enrollment for all infants and children. Please complete the table below for each infant and/or child in your family enrolled at this center/program. Be sure to sign and date in the space below.

The information below must be completed by the parent or guardian.

Infant/Child's First Name	Infant/Child's Last Name	Date of Birth	Normal/Typical Hours of Care	Normal/Typical Days of Care (Circle all that apply)	Meals Normally Eaten (Circle all that apply)
			_____ 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
			_____ to_____	M T W Th F Sat Sun	B AM L PM S LPM

Normal/Typical Hours of Care: Write in each infant/child's usual arrival and departure time. Indicate a.m. or p.m.

Normal Days of Care: Circle the days of the week each infant/child is usually in attendance at the facility.
(M-Monday; T-Tuesday; W-Wednesday; Th- Thursday; F-Friday; Sat-Saturday; Sun-Sunday)

Meals Normally Eaten – Circle the meals each infant/child usually eats at the facility.
(B-Breakfast; AM-AM Snack; L-Lunch; PM-PM Snack; S-Supper; LPM-Late PM/Evening Snack)

Parent/Guardian Signature:_____ **Date:** _____

Print Name: _____

Address: _____

City:_____State:_____Zip Code: _____

Home Telephone Number: **( )**_____Work Telephone Number: **( )** _____

For Facility/Provider Use Only:
Signature of Facility Representative/Provider:_____Date: _____
Date each infant/child withdrew:_____

For State Use Only: Complete:_____Incomplete_____ Reason:_____ Verified by:_____Date:_____

This institution is an equal opportunity provider.