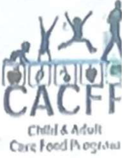
North Carolina Department of Health and Human Services
Division of Public Health
Child and Adult Care Food Program

Child Participant Enrollment Form



INSTITUTION NAME: Chatham County Partnership for Children FACILITY NAME: Center of Excellence Child Care AGREEMENT#: 9422

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 children. Please complete the table below for each child in your family that is enrolled at this center/program. Be sure to sign and date in the space below. Thank you.

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

Child's First Name	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: Please write in each child's usual arrival and departure time. Indicate a.m. or p.m.

Normal Days of Care: Please circle the days of the week each 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 – Please circle the meals each 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 child withdrew: ____________________

For State Use Only: Complete: ______ Incomplete ______ Reason: ____________ Verified by: ____________ Date: ________

This institution is an equal opportunity provider.