



# Iowa Child and Adult Care Food Program

## Child Care Enrollment Form

Postville Childcare Services, Inc. \* PO Box 402 \* Postville Iowa 52162 \* Equal Opportunity Provider

\* This form needs to be filled out per CHILD

Nombre:

Cumpleaños:

\_\_\_\_\_

Indicate the 1. Ethnic and 2. Racial Identity of the enrolled child with a check mark in the appropriate box below. Answering these questions is voluntary and will remain confidential.

<b>1. Ethnic Identity of Child</b>	Hispano o latino americano <input type="checkbox"/>	No Hispano o latino americano <input type="checkbox"/>	<b>2. Racial Identity of Child</b>	Indios americanos o nativos de Alaska <input type="checkbox"/>	Asiático <input type="checkbox"/>	Negro o Afro-Americano <input type="checkbox"/>	Nativo de Hawai u otra isla del Pacifico <input type="checkbox"/>	Blanco <input type="checkbox"/>
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My child's usual times of attendance will be:

Días:    **Lunes**                      **Martes**                      **Miércoles**                      **Jueves**                      **Viernes**

Hours: Arriving at \_\_\_\_\_ Leaving at: \_\_\_\_\_  
 Arriving at \_\_\_\_\_ Leaving at: \_\_\_\_\_

My child's anticipated meal participation will be:

Desayuno                       Almuerzo                       PM Merienda

**Infants Only (0-12 Months):**                       I am not enrolling an infant (skip this section)

As a participant in a USDA Child Nutrition Program, our center offers meals to all ages of children. Infant feeding is based on current nutrition guidelines. Infant foods are appropriate for the age and developmental readiness of your infant. Please select your choice of the following options that will fulfill your infant's food needs.

- I will provide breast milk for my infant. Center formula may be used to supplement feedings if necessary:  
 Yes  No
- I will provide infant formula for my infant. Name of formula: \_\_\_\_\_
- I accept the center's formula for my infant. Name of formula: **Parent's Choice**
- I will provide a statement from a medical authority for non-reimbursable formula.  
 Name of formula: \_\_\_\_\_
- I accept the center's solid foods (appropriately textured) to be served to my infant as s/he is ready for them, and after I have discussed it with the caregiver.
- I will provide solid foods for my infant. The center may supplement with additional solid foods when my infant needs them:  Yes  No

Firma del padre: \_\_\_\_\_ Fecha: \_\_\_\_\_