Nutrition Enrollment Form

Each family must fill out, sign and date this form in order to enroll their child(ren) in the YFS Nutrition Program. All information is required and must be completed. Additionally, you are required to sign each child in and out of the child care program daily. There is no charge for this meal service.

Enrollment Date: _____ Email Address: _____ Phone Number_____

Mailing Address:_____
Street Apt/Lot # City State Zip

Parent Name: _____ Employer: _____ Phone: _____

Parent Name: _____ Employer: _____ Phone: _____

Child(ren) in Care:

Child's First and Last Name	Date of Birth	Circle Days In Care	Specify Times In Care	Circle Meals Eaten	Relationship To Provider	Circle School Age Y/N
1. _____	___/___/____	S M T W R F S	____to_____	B A L P S E	_____	Yes / No
2. _____	___/___/___	S M T W R F S	____to_____	B A L P S E	_____	Yes / No
3. _____	___/___/___	S M T W R F S	____to_____	B A L P S E	_____	Yes / No

Circle Ethnicity: Hispanic or Latino or Non Hispanic or Latino

Circle Race: Native American/ Black or African American/ Native Hawaiian or Pacific Islander/Asian/White

Circle Ethnicity: Hispanic or Latino or Non Hispanic or Latino

Circle Race: Native American/ Black or African American/ Native Hawaiian or Pacific Islander/Asian/White

Circle Ethnicity: Hispanic or Latino or Non Hispanic or Latino

Circle Race: Native American/ Black or African American/ Native Hawaiian or Pacific Islander/Asian/White

*B= Breakfast, A= Morning Snack, L= Lunch, P= Afternoon Snack, S= Supper, E=Evening Snack

Relationship To Provider Code: Helpers Child, Not Related/Daycare Child, Own Child, Provider's Foster Child, Related/Non Resident

**** If child is under 12 months please fill out the Infant Menu Form**

The Child and Adult Care Food Program ensures your children are eating nutritious meals and snacks while in your provider's care. The WIC Program is a supplemental nutrition program for eligible women, infants, and children funded by the U.S. Department of Agriculture and administered by the South Dakota Department of Health. For the number of the local WIC office, call (800) 738-2301.

Parent Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Provider Name (print): _____

This institution is an equal opportunity provider and employer.