CACFP Infant Enrollment Form

Center/Provider Name:_____

Dear Parent/Guardian,
This childcare center/provider participates in the Child and Adult Care Food Program (CACFP) and receives USDA reimbursement for serving nutritious meals to infants according to program requirements. Participation in this program requires childcare centers/providers to follow specific meal patterns according to the age of the infant.

Childcare centers/providers participating in the CACFP **are required** to offer at least one iron fortified infant formula for infants who are enrolled in care. You may decline the infant formula offered, and supply breast milk and/or your own CACFP approved iron-fortified formula.
(NOTE: A CACFP approved iron-fortified formula must have 1 mg of iron or more per 100 calories of formula when prepared using the label directions and must be regulated by the FDA.)

Additionally, when you determine, in consultation with your physician, that your infant is developmentally ready, the childcare center/provider will also be **required** to offer iron fortified infant cereal and other infant foods.

Infant's Name_____Infant's Date of Birth_____

Iron Fortified Formula offered by the Center/Provider___Member's Mark Advantage Premium_____

Breast milk and/or Formula preference

Record date to indicate your preference (choose all that apply) *I understand that I may change my decision at any time with advance notice	**Birth -5 months Date & Initial**	**6 – 11 months Date & Initial**
I will provide expressed breast milk for my infant.		
I will breast feed my infant on site at the center/provider.		
I want the childcare center/provider to provide the infant formula it offers for my infant.		
I will provide the infant formula for my infant. (must be iron fortified) **Name of infant formula I will provide: _____**		
My infant has a special dietary need that requires a formula that does not meet the criteria for an approved iron fortified formula. I have provided the center/ provider with a **Medical Plan of Care** signed by a licensed medical authority that includes the impairment that restricts the infant's diet, how it effects the infant, and the recommended substitution. **Name of infant formula: _____** ☐ Center will provide the formula. ☐ I will provide the formula.		

Preference regarding infant cereal and other foods

Record date to indicate your preference *I understand that I may change my decision at any time with advance notice	**6 – 11 months Date & Initial**
I want the childcare center/provider to provide the iron fortified infant cereal and other foods for my infant.	
I want the childcare center/provider to provide all food items with one exception. (This option is only applicable if center/provider is providing the iron-fortified infant formula) **One food item that I will provide (must be a creditable CACFP food item): _____**	
My infant has a special dietary need that requires modifications to the infant meal pattern requirements. I have provided the center/provider with a Medical Plan of Care signed by a licensed medical authority that includes the impairment that restricts the infant's diet, how it effects the infant, the foods to avoid and the recommended substitutions	
I am aware and understand the all information provided on this form and my ability to have my infant participate in the CACFP; however, **I decline** the infant formula and food offered by the center/provider and elect to furnish ALL infant formula and food for my infant. **(Center/Provider may not claim meals for this infant)**	

_____ **_____**

Parent/Guardian **Date** **Center/Provider signature** **Date**

This supplemental infant form must be completed for all infants in care and must be maintained by center/provider and if applicable, a copy must be maintained by the Sponsoring organization.

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

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