PROVIDER DATA SHEET

2025

Authorization Number D-1793

Organization Name Children's Nutrition of Florida, Inc.

1. Provider Information

Provider Name _____

Street Address _____

City _____ State FL Zip _____ County _____

Home Phone # _____ Cell Phone # _____

Email Address _____ @ _____

2. List the names of all children under 13 that live in your home _____

_____

3. Days you provide care for children ❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday

4. Operating Hours (per DCF License) Start_____ Finish _____

5. Meals Claimed ❑ Breakfast ❑ Morning Snack ❑ Lunch ❑ Afternoon Snack ❑ Supper

6. Meal Times:

	Start	Finish
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Supper		

OFFICE USE ONLY (REQUESTED/APPROVED CHANGES)	
Start	Finish

7. Holidays you will be serving and claiming meals

- ❑ New Years Day
- ❑ Good Friday
- ❑ Labor Day
- ❑ Fri. after Thanksgiving
- ❑ MLK Jr. Day
- ❑ Memorial Day
- ❑ Veteran's Day
- ❑ Christmas Eve
- ❑ President's Day
- ❑ Independence Day
- ❑ Thanksgiving Day
- ❑ Christmas Day
- ❑ Juneteenth

8. Is your name, address and phone number listed CONFIDENTIAL with DCF? ❑ Yes ❑ No

9. Do you transport children and if so, list times _____

I certify that all information on this Provider Data Sheet is true and correct.

_____
Provider's Signature

_____
Signature Date

Approved by _____

Title_____

Date _____