



CHILD CARE FOOD PROGRAM ENROLLMENT FORM

DAY CARE PROVIDER'S FIRST AND LAST NAME:

FIRST

LAST

Student Information:

Original **Date of Enrollment:** _____ / _____ / _____
Month Day Year

Child's Date of Birth: _____ Sex: _____

Child's Full Name: _____
Last First Middle

Child's Address: _____

City: _____ State: FLORIDA ZIP: _____

Primary Hours of Care: From _____ To _____

Days of the Week in Care: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Meals Typically Served: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper

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FAMILY Information:

Mother/Guardian: _____

Father/Guardian: _____

Address: _____

Address: _____

Home Phone: _____

Home Phone: _____

Alternate Phone: _____

Alternate Phone: _____

Custody: Mother _____ Father _____ Both _____ Other _____

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By signing below, you verify that all information on this enrollment form is complete and accurate.

Signature of PARENT/GAURDIAN

_____/_____/_____
MONTH DAY YEAR