CHILD'S ENROLLMENT FORM

Child's Information: ______________ ______________ ______________ ______________ ______________
Last Name First Name Middle Name Birthday Sex

Address: ______________ ______________ ______________ ______________
Street City Zip Code Phone Number

Parent/Guardian Information:

______________ ______________ ______________ ______________
Father's Name Work Address Work Phone Number Cell Phone Number

______________ ______________ ______________ ______________
Mother's Name Work Address Work Phone Number Cell Phone Number

Emergency Information

Allergies: ____

Significant Medical Information of Special Needs: ____

____

Physician: ______________ Address: ______________ Phone Number: ______________

Hospital: ______________ Address: ______________ Phone Number: ______________

I give permission for Emergency Medical

Transportation: ☐ YES ☐ NO ______________ Initial of parent/guardian

Treatment: ☐ YES ☐ NO ______________ Initial of parent/guardian

Name 2 LOCAL Emergency Contacts (Other than parents or guardians).

1. ____
Name: Address: Phone Number:
2. ____
Name: Address: Phone Number:

At the end of the day or during any day, my child may be released to the person or persons that have legal custody or the following persons. It is understood that identification will be verified at the time of pickup:

1. ______________ 2. ______________
3. ______________ 4. ______________

My child will be attending the following days and times:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

☐ My child will attend between the hours of 6:00AM to 6:00PM

☐ Days and times my vary

I have read and understand the parent handbook: ______________ Parent/Guardian Initial

______________________ ______________

Parent or Guardian Signature Date:

Kiddie Kamp Daycare/Preschool

Emergency Contact List

Child's Name ________________________________ DOB ________

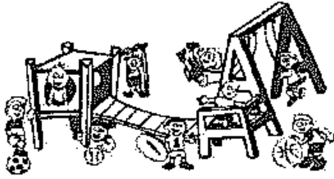
Name: ____
Relationship to child: ______________________________________
Address: ____
Phone #: ____

Name: ____
Relationship to child: ______________________________________
Address: ____
Phone #: ____

Name: ____
Relationship to child: ______________________________________
Address: ____
Phone #: ____

Name: ____
Relationship to child: ______________________________________
Address: ____
Phone #: ____

Name: ____
Relationship to child: ______________________________________
Address: ____
Phone #: ____



Kiddie Kamp Daycare/Preschool

Sunscreen/Diaper Ointment/Lotion/Insect Repellent Permission Slip

Child's Name ____

Parent's Name ____

Sunscreen

☐ Yes, I give permission to the Kiddie Kamp Daycare staff to apply No-Ad brand sunscreen (SPF 45) to my child during the course of the day.

☐ No, please do not apply No-Ad brand sunscreen to my child. I will provide my own sunscreen for use on my child. I will label it with my child's name.

Lotion

☐ Yes, I give permission to the Kiddie Kamp Daycare staff to apply lotion to my child during the course of the day.

☐ No, please do not apply lotion to my child. I will provide my own lotion for use on my child. I will label it with my child's name.

Diaper Ointment

☐ Yes, I give permission to the Kiddie Kamp Daycare staff to apply diaper ointment o my child. I agree to supply the nonprescription ointment that is most effective for use by my child. I will label it with my child's name.
NOTE: Prescription diaper ointment will be treated as any other prescription medication. Ointment must be in the original container with child's name, doctor's name, and instructions for application. It will be kept in a locked cabinet.

Insect Repellent
When public health authorities recommend use of insect repellents due to a high risk of insect-borne disease, only repellents containing DEET will be used. Staff will aply insect repellent no more than once a day and only with written parental permission.

☐ Yes, I give permission to the Kiddie Kamp Daycare staff to apply insect repellent to my child.

☐ No do not apply insect repellent to my child.

____ Date ____________________
Parent/Guardian Signature

All About Me

Name: ______________________________ We call him/her: ________________

Date of Birth:____________ Age: __________ Allergies: ______________________

Does your child take prescription medication(s) on a regular basis? ________________

Parents: Guardians:

Mother: ______________________________ Phone:________________

Father: ______________________________ Phone:________________

If child does not live with parents who are the primary caregivers: ________________

Brothers and Sisters:

______________________________ Age: ________________

______________________________ Age: ________________

______________________________ Age: ________________

Language spoken in home: ______________________________

Holiday's Celebrated: ______________________________

____

Culture/Family Background: ______________________________

____

Religion: ______________________________

Fears: ______________________________

Child's Eating Habits: ______________________________

Favorite Foods: ________________Disliked Foods: ________________

Discipline: ______________________________

Absolute No-Nos______________________________

Other: ______________________________

Dear Parents/Caregivers,

Here at Kiddie Kamp we are starting a new screening and monitoring program. Because your child's first 5 years of life are so important, we want to help you provide the best start for your child. As part of this service, we provide the Ages and Stages Questionnaires, Third Edition (ASQ-3), to help keep track of your child's development. You can review these questionnaires after our teachers fill them out or choose to fill them out yourself. The questionnaires include questions about what your child can or can't do including questions about your child's communication, gross motor, fine motor, problem solving, and persona'-social skills.

If the questionnaire shows that your child is developing without concerns, we will provide some activities designed for use with ASQ-3 to encourage your child's development and will provide the next questionnaire at the appropriate time.

If the questionnaire shows some possible concerns, we will share a resource list with you.

Please read the text below and initial the desired space to indicate whether you will participate in the screening/monitoring program.

______ I have read the information provided about the Ages & Stages Questionnaires, and I wish to have my child participate in the screening/monitoring program.

______ I do not wish for my child to participate in the screening/monitoring program. I have read the provided information and understand the purpose of this program.

Parent/Guardian Signature:______________________________ Date:__________________

Childs Name: __________________________ Childs date of birth:__________________________

If child was born 3 or more weeks prematurely, # of weeks premature:____________________

Child's primary physician:____

Allergy Form

Child's First Name Last Name

Allergy(ies)

Physician Name/Phone number

Hospital Preferred

Epi pen required along with physician's signature

Physician Signature Date

Parent/Guardian Signature Date

Kiddie Kamp Inc. Daycare & Preschool

401 NE Aztec Blvd
Aztec, NM 87410
(505) 334-8268

2004 Brothers Ave
Farmington, NM 87402
(505) 325-9667

1304 Schofield Lane
Farmington, NM 87402
(505)326-7735

HEALTH EXAMINATION FOR ENTRY INTO PROGRAM
****COPY OF CURRENT "WELL CHILD" EXAM IS ACCEPTABLE****

Dear Health Care Provider:

As a step in the process of enrolling their child in our program, we request that each parent provide a statement as to the health of their child. Would you please answer the following questions for our center? Thank you!

Today's Date: ________________ Childs Name: ________________________

Sex: _________ Age: _________ Birth Date: __________ Height: _________ Weight: _________

Significant Medical History:

____

____

____

Physical Examination (list of abnormal findings only):

____

____

____

General Health of Child:

____

____

____

Signed: _______________________
(Health Care Provider)

Address: ______________________

Telephone: ____________________

Kiddie Kamp Inc. Daycare & Preschool

401 NE Aztec Blvd
Aztec, NM 87410
(505) 334-8268

2004 Brothers Ave
Farmington, NM 87402
(505) 325-9667

1304 Schofield Lane
Farmington, NM 87402
(505)326-7735

A Current Dental "Well Child" Report is acceptable

Today's Date: ______________

Child's Name: ______________________________

I have performed an oral examination for this child and have informed his/her parents of any and all necessary dental treatments.

Is in current treatment:

____

____

____

Treatment completed:

____

____

____

Signed: __________________________
(Dentist)

Address: _________________________

Telephone: _______________________

KIDDIE KAMP DAYCARE/PRESCHOOL

Health and Wellness Form

Please complete the table below indicating the most recent health screenings your child received and/or the date of the next scheduled appointment. We will update this form yearly.

Please make sure to bring in any new record of shots your child has or will receive.

	Date of most recent Office Visit	Date of Next Scheduled appointment
Well child check		
Dental screening		
Vision screening		
Hearing screening		

______________________________ ______________

Signature of Parent or Legal Guardian Date

Only sign below if you did not complete information above.

I have chosen not to take my child in for a yearly well-child check, dental screening, vision screening and/or hearing screening, and I acknowledge I have received a resource list with contact information of local health agencies that provide these important services.

______________________________ ______________

Signature of Parent or Legal Guardian Date

Kiddie Kamp Daycare/Preschool

Request for Administration of Medication

Child's Name ____ DOB _________

Check Type of Medication: Prescription ______ Non-Prescription ______

Name of Medication: ____

Dosage to be Administered ____

Medication Expiration Date ____
Time Medication is to be Administered 1______ 2______ 3______
Dates Medication is to be Administered Begin ___________ End ____________
Time of Last Dose Given ____
Is child taking any other medication at this time? Yes _____ No _____
I request the staff of Kiddie Kamp Child and Family Development Center administer the above medication according to the prescribed information.

____ Date _____________________
Parent/Guardian Signature

MEDICATION LOG FOR ____

Name of Medication	**Dosage Given**	**Date**	**Time**	**Admin. By**	**Parent Initial**

ALL MEDICATION MUST BE IN ITS ORIGINAL CONTAINER

Administration Complete.
Medication returned to parent (date) __________ (by) __________________________

Kiddie Kamp Parent Orientation

Child's Name	Parent initials
I have received a tour of the facility	
I have met my child's teacher(s) and other staff members	
I have received a parent handbook	
I understand that my child needs diapers and wipes and I am responsible to make sure they have enough for the hours they are in attendance	
I understand that my child needs a crib sheet and a blanket for rest / nap time	
I understand that my child needs an extra set of clothes in his / her cubby	
I understand that Kiddie Kamp is not responsible for lost items and I need to label all his/her belongings	
To preserve harmony and ensure that nothing gets lost / stolen I will not bring toys from home and I will not take items that belong to Kiddie Kamp home	
I understand that Kiddie Kamp is not responsible for items and I need to label all his/her belongings, if items are left after disenrollment, they will be donated	
I am aware that Kiddie Kamp's hours are 6:00 am – 6:00 pm; I need to make necessary arrangements to ensure my child is picked up by 6:00 pm. Kiddie Kamp will charge a $5.00/minute fee per child after 6:00 pm and I will not be able to return until that fee is paid.	
I understand that if I am CYFD I am responsible for all copays and taxes and I am aware of the late fee of $25.00/ child that will be implemented after the 15th of month if not paid.	
I understand there is a $12.50/month supply fee that is due no later than the 10th of each month. Not applicable for CYFD parents.	
If I am private pay, I understand that my child's tuition is due on the Friday before the next week.	
I understand that no outside food is permitted without a doctor's note regarding allergies	
I give Kiddie Kamp authorization to photograph my child and use said pictures in and around classroom	
I give Kiddie Kamp authorization to post pictures of my child on the official Kiddie Kamp Social media.	
I understand that Kiddie Kamp needs a well child check up and updated immunization records throughout their enrollment	
Kiddie Kamp is here to support you and your families' resources and activities to help with child growth and development	
Kiddie Kamp We have an open-door policy and you may come and visit with your child in their classroom at any time	
Resources are available to ensure the success of your child if you need anything please feel free to contact Karri Watson, Director at (505) 334-8268	

Parent signature ____ Date__________

Child and Adult Care Food Program
LETTER TO HOUSEHOLDS

Name of Facility / Center / Site / Home Provider (Last, First, Middle Initial):	Facility / Center / Site / Home Provider EPICS ID:	Phone Number
Kiddie Kamp Inc.	Aztec	505 334 8268

Instructions: This letter must accompany the Income Eligibility Application.

Dear Parent / Guardian or CACFP Participant:

Kiddie Kamp Inc. Participates in the Child and Adult Care Food Program (CACFP) administered by the United States

Name of Facility / Center / Site / Home Provider (Last, First, Middle Initial)

Department of Agriculture. Please help us comply with the requirements of the CACFP by completing, signing, and returning the attached statement as soon as possible. This information is necessary to decide the level of CACFP reimbursement your center is eligible to receive for the meals served to children and/or adult participants in our program. This form will be treated as confidential information. All participants in our program receive their meal free of charge, but the determination of eligibility category affects the amount of federal funding we receive. Foster Children: A foster child enrolled in our program that is the legal responsibility of a welfare agency, or court may be certified as eligible for free meals regardless of your household income. Please refer to the instructions on how to complete the Income Eligibility Application form.

SNAP - Supplemental Nutrition Assistance Program (formerly the Food Stamp Program): If your household is currently receiving benefits under the Supplemental Nutrition Assistance Program (SNAP) or Food Distribution Program on Indian Reservations (FDPIR) and your child is enrolled in a child care center you need only to list the case number sign and date the form.

If your household is receiving benefits under the Supplemental Nutrition Assistance Program (SNAP), Supplemental Security Income (SSI), Medicaid or Food Distribution Program on Indian Reservations (FDPIR) and an adult in your home is enrolled in an Adult Daycare Center then you need only to list their case number sign and date the form. Otherwise, an adult household member must complete the form and disclose total current household income by source, and the names of all household members. The person completing the form must sign, provide a social security number, and date when completed.

The income you report must be last month's total gross household income listed by source, for each household member. If last month's income does not accurately reflect your circumstances, you may provide your annual income, or you may use last year's income if no significant changes have occurred. If your households' income is equal to or less than the amounts indicated for your households' size on the chart below, your provider may qualify for maximum reimbursement rates. The Department of Agriculture defines a household as a group of related or unrelated individuals (not residents of a boarding house or an institution) who are living as one economic unit (i.e., sharing living expenses).

INCOME ELIGIBILITY GUIDELINES - (EFFECTIVE FROM JULY 1, 2022 TO JUNE 30, 2023)

	FREE			REDUCED		
HOUSEHOLD SIZE	YEAR	MONTH	WEEK	YEAR	MONTH	WEEK
1	17,667	1,473	340	25,142	2,096	484
2	23,803	1,984	458	33,874	2,823	652
3	29,939	2,495	576	42,606	3,551	820
4	36,075	3,007	694	51,338	4,279	988
5	42,211	3,518	812	60,070	5,006	1,156
6	48,347	4,029	930	68,802	5,734	1,324
7	54,483	4,541	1,048	77,534	6,462	1,492
8	60,619	5,052	1,166	86,266	7,189	1,659
	6,136	512	118	8,732	728	168

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: How to File a Complaint, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

Kiddie Kamp Inc.	[signature]	1/3/22
Name of Sponsor / Center Representative	Signature of Sponsor / Center Representative	Date

Child and Adult Care Food Program
INSTRUCTIONS FOR COMPLETING THE INCOME ELIGIBILITY FORM

Name of Facility / Center / Site / Home Provider (Last, First, Middle Initial): Kiddie Kamp Inc.	Facility / Center / Site / Home Provider EPICS ID: Aztec	Phone Number (505) 334 / 8268

PARTICIPANT INFORMATION:

List name of all enrolled participants that you are applying for which are in care.

List each enrolled participant's date of birth.

If you are applying for a foster child, list only one foster child per form. A foster child may be eligible for free meals regardless of household income.

Child Care Centers: If the participant enrolled is in a Child Care Center and receives benefits through Supplemental Nutrition Assistance (SNAP), *(formerly food stamps or Food Distribution Program on Indian Reservation (FDPIR)*, please indicate the appropriate **case number** in the spaces provided and sign the form. Do not use the number on your card. You do not need to complete household and income information.

Adult Day Care Centers: If the participant enrolled is in an Adult Daycare Center and receives benefits thru Supplemental Nutrition Assistance (SNAP) formerly, food stamps, Food Distribution Program on Indian Reservation (FDPIR), Supplemental Security Income (SSI) or Medicaid, please indicate the appropriate **case number** in the spaces provided and sign the form. Do not use the number on your card. You do not need to complete household and income information.

If you do not receive benefits and have no case number for participants enrolled at the center, you must complete all parts of the IEA (Household and Income information).

HOUSEHOLD AND INCOME INFORMATION

Not required to be completed if case# is provided above.

List all household members. A household is a group of related or unrelated individuals who are living as one economic unit (i.e. sharing living expenses).

Provide the most current income by source for all household members. This can be based on the most recent information the month prior to completing the application.

Reported income needs to be reported on the same. The income reported on the application must include all income before taxes and before other deductions.

A foster child, defined as a ward of the court or welfare agency. Only the foster child's "personal use" income is listed.

Personal use income includes:

- Funds that are specified by the welfare agency as being for the personal use of the child. (If no funds are specified, the funds received from the welfare agency are not to be considered as income. Record "0" on personal income.)
- Money received from any source. This includes, but is not limited to, funds received from trust accounts, from the child's family, and earnings from the child's employment other than occasional or part-time jobs.

SIGNATURE

The adult family member completing the application must sign and date the application.

If the enrolled participant is not a recipient of benefits and has not provided a case number, the adult family member signing the application must provide a social security number.

If you do not have a social security number, check the "box" provided. Otherwise, failure to provide the social security number (if you have one) will make the Income Eligibility Application invalid and will reduce the level of CACFP reimbursement your family's Child Care Center receives for meals served to the children and/or adult participants enrolled for care in their center.

INCOME ELIGIBILITY APPLICATION

Free and Reduced Meals in the Child and Adult Care Food Program

Center Name Kiddie Kamp Aztec

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by 1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider

INSTRUCTIONS: Complete this form and return it to the center's office. ***Notation: (SNAP)*** *Supplemental Nutrition Assistance Program (formerly the Food Stamp Program)*

***Child Care Centers**: To apply for **FREE** meals - If you are receiving benefits under the Supplemental Nutrition Assistance Program (SNAP) or Food Distribution Program on Indian Reservations (FDPIR) fill in your child's name, date of birth, age, the SNAP Case number or FDPIR case number and sign the form. DO NOT complete other Household Members or income information.

****Adult Day Care**: To apply for **FREE** meals - If the enrolled participant household is the recipient of the Supplemental Nutrition Assistance Program (SNAP) or receives Supplemental Security Income (SSI) or Medicaid (MED), complete name, DOB, age, SNAP, SSI, and/or Medicaid case number and sign the form. DO NOT complete other Household Members or incomeinformation.

Enrolled Participant(s) Information (attach additional pages if necessary)				**Benefit Information** *(If applicable check the type of benefit & provide the required case number)*	
First and Last Name	If foster Child Check here	Date of Birth:	Age	****Child Care Centers Only**-check a box* ☐SNAP ☐FDPIR	*****Adult Care Centers Only**- check a box* ☐SNAP ☐FDPIR ☐SSI ☐MED
	☐	/ /		*Case Number:	**Case Number:
	☐	/ /			
	☐	/ /			
	☐	/ /			

Foster Child (complete if a foster child is enrolling for care)

☐ Check this box if this application includes a foster child. List the amount of the child's "personal use" monthly income

All Other Household Members List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to

First and Last Name	***First and Last Name***

Total Number in Households: ____________

Household Income (Please indicate the source and amount of current income for all members of your household. Please follow the definition of income specified in the standards for determining free and reduced-price eligibility in your parent letter. If you receive more than one check from any of these sources, please indicate the total monthly amount received.)

Wages, Salary: $	Child Support (Alimony): $	Social Security: $
Pension or Retirement: $	Unemployment: $	Other Income: $

If necessary, convert multiple income schedules to annual income (Multiply weekly income by 52, biweekly by 26, monthly by 12)

Total Income: $____________ ☐**Weekly** ☐**Monthly** ☐ **Annually** *(Check one)*

Penalties for Misrepresentation: I certify that all the above information is true and correct and that the food stamp or FDPIR number is correct or that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the statement and that the deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

☐ **check if no Social Security Number**

Signature of Adult Family Member or guardian ***Social Security Number*** Date

This explains how we will use the information you give us. The Richard B. Russell National School Lunch Act requires that, unless the participant's food stamp or FDPIR number is provided, you must include the social security number of the household member signing the statement or an indication that the household member signing the statement does not possess a social security number. Provision of a social security number is not mandatory, but if a social security number is not provided or an indication is not made that the adult household member signing the statement does not have one, the statement cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of the information on the statement. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a food stamp or FDPIR office to determine current certification for receipt of SNAP (food stamp) or FDPIR benefits, contacting the State employment security office to determine the number of benefits received and checking the documentation produced by the household member to verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims, or legal action if incorrect information is reported.

FOR SPONSOR USE ONLY

☐ **Child Day Care Center:**

☐ **Adult Day Care Center:** ☐ **Approved Free** ☐ **Approved Reduced** ☐ **Paid**

Kiddie Kamp Inc.

Approving Date *Date Disenrolled* *Name of Organization* *Name of Person Approving Form*

Revied 5-27-22

Form 025

Obligation to Offer Infant Formula and Food

CENTER AGREEMENT#: 0635 Child & Adult Care Food Program - Kiddie Kamp FAMILY #: ________

Center Name

Dear Parent:

This Child Care Center offers Members Mark *(Name of House Formula)* Iron Fortified Infant Formula for infants less than 12 months of age as part of our participation in the Child and Adult Care Food Program (CACFP).

We are required to follow the CACFP Infant Meal Pattern for infants at no additional charge to you. We are pleased to offer these benefits for as long as this center is eligible to participate. To better meet your personal preferences and your infant's needs, you may choose from the following options. Please check your selection, sign, and date this form. If your decision changes, you may fill out a new form. Also, if the situation changes such as your pediatrician changing the infant's formula, then a new form should be filled out as well. The 'old' form will be kept on file.

A form must be completed for every infant enrolled at our center that does not take our "house formula".

** **Please Note: We are providing formula to be used at our center ONLY.** If your infant's current formula is different, we strongly recommend that you check with your pediatrician before switching. Remember, you may choose to use our house formula at no extra charge or provide your own brand.

Infant's Name: ____________________ Date of Birth: ____________

____ I **accept** the formula offered by this child care center *which is* Members Mark *(Name of House Formula)* *Iron Fortified Infant Formula*

____ I **decline** the formula offered by this child care center **AND I will provide** ____________ **(formula brand name or breast milk)**

** I understand the center staff will serve infant formula and infant food according to the planned infant menus and the CACFP meal pattern. If I provide my own formula or breastmilk, I will clearly label the bottles with my infant's name and the date.

PARENT'S SIGNATURE: ____________________
Signature and Date

CENTER STAFF SIGNATURE: Kari L Watson
Signature and Date

From I-A (08/09)

The State of New Mexico Children, Youth and Families Department, Child and Adult Care Food Program does not discriminate on the basis of age, color race, sex, national origin or disability. Any person who believes they have been discriminated against in any USDA-related activity should contact: USDA, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD).