Family Day Care Network
1115 W. 41st Street
Sioux Falls, SD 57105
(605) 333-0663 • 1-800-235-5923

ENROLLMENT FORM

Provider Name: ___________________
FDCN Number: __________________
Date: ____________________________

Our agency participates in the Child and Adult care Food Program (CACFP) and receives Federal Reimbursement for the meals served to your child(ren). The Federal regulations for the CACFP require us to collect and update this information on an annual basis for all of our enrolled children. This information is used to confirm your child(ren)'s current enrollment in the facility and thus in the CACFP. All information is confidential and will be shared with appropriate personnel and state/ federal staff as needed. Note: The indication of racial and ethnic background is optional and will not affect eligibility for the Program. This information is used for reporting purposes only. By providing this information you will assist us in assuring that this program is administered in a nondiscriminatory manner. If racial/ ethnic background is not reported, a visual identification of the child's race and ethnicity will be made.

Children in Care: **(Please Circle All that Apply)**

Full Names:	Race/Ethnicity*	Date of Birth	Normal Hours in Care	Normal Days of Care	Meals Normally Eaten at Facility**
			to	Su M Tu W Th F Sa	B AM L PM Su Ev
			to	Su M Tu W Th F Sa	B AM L PM Su Ev
			to	Su M Tu W Th F Sa	B AM L PM Su Ev
			to	Su M Tu W Th F Sa	B AM L PM Su Ev

* **Race**: Hispanic or Latino **Ethnicity:** American Indian or Alaskan Native/ Asian/ Black or African American/ Native Hawaiian or other Pacific Islander/ White

** **B**=Breakfast **AM**=Am Snack **L**=Lunch **PM**=PM Snack **SU**=Supper **EV**= Evening Snack

☐ List any holidays that may require care:____

☐ Special Needs or Instructions:____

Parents/Guardian's Name: ______________________________________Phone:____________________

Home Address: ______________________________ City: __________________State: ______Zip:_________

Mother's Employer: ______________________________Phone: __________________Cell:________________

Father's Emplyer: ______________________________Phone:__________________Cell:________________

In Emergency Call:

1.______________________________Phone:__________________2.____________________________Phone:______________________

Physician's Name: ____Phone:________________________

Dentist's Name: ____Phone:________________________

☐ I here by give ____________________________________, our day care provider, permission for emergency treatment at (Clinic/Hospital) ____.

☐ I also understand that I will be notified each time my child is to ride in a motor vehicle.

Person's authorized to Remove Children: ____

Initial Enrollment Date: _____________________ **Update Date**: _________________________**Dismissal Date:** ______________________

____ ____

Provider's Signature **Parent's Signature**

Top Copy: Family Day Care Network **Yellow Copy:** Provider's Records **Pink Copy:** Dismissal Copy

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

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Date Entered: _________________Staff Initials: _____