

CACFP Infant Feeding Benefit Notification and Acknowledgement

**Return to
Northwest
Nutrition**

Infant's Name: _____ DOB: _____
 Provider's Name: _____

To: Parents/Guardians of infants, birth through 11 months old

Your family day care provider participates in the Child and Adult Care Food Program (CACFP). The CACFP is administered by the Oregon Department of Education and is funded by the United States Department of Agriculture (USDA). The CACFP provides reimbursement for healthy meals provided and served to your baby while in care. Your family day care home provider follows the USDA Meal Pattern for Infants shown below. The types and amounts of food vary according to the age and developmental readiness of your baby. As the parent/guardian, you are the main source for nutritional and developmental information for your baby.

USDA supports and encourages moms to continue breastfeeding when returning to work or school. For formula fed infants, the following USDA-approved iron-fortified infant formula(s) will be provided to babies in care:

Milk-based iron-fortified formula: _____

Soy-based iron-fortified formula: _____

| USDA Meal Pattern Requirements For Infants | | | |
|---|--|---|---|
| Age | Breakfast | Lunch or Supper | Snack |
| 0 - 3 months | 4-6 fluid ounces iron-fortified formula or breast milk | 4-6 fluid ounces iron-fortified formula or breast milk | 4-6 fluid ounces iron-fortified formula or breast milk |
| 4 - 7 months | 4-8 fluid ounces iron-fortified formula or breast milk Optional: 0-3 Tbsp iron-fortified infant cereal | 4-8 fluid ounces iron-fortified formula or breast milk Optional: 0-3 Tbsp iron-fortified infant cereal Optional: 0-3 Tbsp fruit and/or vegetable | 4-6 fluid ounces iron-fortified formula or breast milk |
| 8 - 11 months | 6-8 fluid ounces iron-fortified formula or breast milk AND 2-4 Tbsp iron-fortified infant cereal AND 1-4 Tbsp fruit and/or vegetable | 6-8 fluid ounces iron-fortified formula or breast milk AND 2-4 Tbsp iron-fortified infant cereal AND/OR 1-4 Tbsp meat, fish, poultry, egg yolk, or cooked dry beans or peas; or ½ - 2 oz cheese; or 1-4 oz (volume) cottage cheese; or 1-4 oz (weight) cheese food, or cheese spread AND 1-4 Tbsp fruit and/or vegetable | 2-4 fluid ounces iron-fortified formula or breast milk or 100% fruit juice Optional: ½ slice bread or 0-2 crackers (made from whole grain or enriched flour) |

You have a right to the benefits described in this letter. If you choose not to take part in the CACFP you may supply your own breast milk and/or formula and foods for your infant. You have the right to CACFP benefits in the future. If you choose to accept CACFP benefits in the future, you must notify your family day care home provider. If you feel these benefits are not being offered as described in this letter, contact:

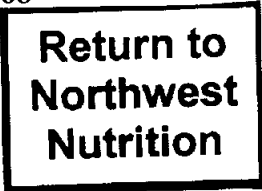
NORTHWEST NUTRITION SERVICE, INC
 (503) 653-7626/1-800-600-6058

This family day care provider has not requested or required me to provide infant formula or food for my baby. I understand that I have the choice of having my baby participate in the CACFP. I have received a copy of this form for my records.

Parent/Guardian Signature

Date

The effective date for claiming meals is the date the form is signed



FOR ENROLLMENT OF INFANTS ONLY (6 weeks – 1 year)

This form is to be filled out by the parent/guardian only.

| Name of Child Last, First | Birth date | Hours of Care | | Check Meals Needed | | | | |
|------------------------------|------------|---------------|-------|--------------------|---------|----|--------|------|
| | | Ex: 8am – 5pm | Bkft | AM | Lun | PM | Dinner | Late |
| | | | 6-9am | | 11-1:30 | | 5-7pm | |
| | | start: | | | | | | |
| | | end: | | | | | | |
| | | start: | | | | | | |
| | | end: | | | | | | |

Check the days of the week that the infant will be in care:

Monday__ Tuesday__ Wednesday__ Thursday__ Friday__ Saturday__ Sunday__

RACIAL OR ETHNIC IDENTITY (not required)

Please check your child's racial ethnic identity.

Mark one ethnic identity

Mark one or more racial identities, if any;

Hispanic or Latino

American Indian & Alaskan Native

Native Hawaiian or Other Pacific Islander

Not Hispanic or Latino

Asian

White

Black or African American

Other: _____

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discrimination 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, SW, Washington, D.C. 20250-9410 or call, toll free (866) 632-9992 (Voice). TDD users can contact USDA through local relay or the Federal relay at (800) 877-8339 (TDD) or (866) 377-8642 (relay voice users). USDA is an equal opportunity provider and employer.

I wish to enroll my child/children whose names and enrollment information are given above, in the Child and Adult Care Food Program, which reimburses day care providers for serving nutritious, well- balanced meals to day care children. I have received a copy of the **Infant Feeding Benefit Notification and Acknowledgement form after signing.**

Parent/Guardian (print your name) _____

Parent/Guardian Signature _____

Dated _____

The effective date for claiming infant meals is the date the form is signed by the parent/guardian.

Parent/Guardian Address: _____

Street

City

Zip code

Daytime telephone: _____

Evening telephone: _____

CACFP Infant Feeding Benefit Notification and Acknowledgement

**Parent
Copy**

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