



**PARENT/GUARDIAN CHOICE FORM (INFANT)**

<b>NAME OF INFANT:</b>		<b>DATE OF BIRTH:</b>	
	<i>(First Name, Middle Initial, Last Name)</i>		<i>(mm/dd/yyyy)</i>

This center/provider participates in the Child and Adult Care Food Program (CACFP) and receives Federal USDA funding for serving nutritious meals to infants and children. Participation in the CACFP requires caregivers to follow specific meal patterns according to age group classifications detailed in forms *CACFP-009 Child Meal Pattern* and *CACFP-010 Infant Meal Pattern*.

(Center/Provider) \_\_\_\_\_ agrees to feed your infant breast milk provided by parent/guardian. The center/provider will provide iron-fortified infant formula. The formula provided is \_\_\_\_\_.

Federal regulations require centers/providers participating in the CACFP to offer iron-fortified formula to infants who are in care during meal service times. Parents/guardians may decline the center/provider offered formula and supply the infant’s formula, provide expressed breastmilk, or breastfeed on site.

PLEASE INDICATE PREFERENCES <i>(Choose all options that apply by initialing and dating in the appropriate space(s))</i>	BIRTH – 5 MONTHS	6 MONTHS – 11 MONTHS
<b>OPTION 1:</b> CENTER/PROVIDER OFFERED IRON-FORTIFIED FORMULA	INITIALS: _____ DATE: _____	INITIALS: _____ DATE: _____
<b>OPTION 2:</b> PARENT/GUARDIAN WILL PROVIDE FORMULA	INITIALS: _____ DATE: _____	INITIALS: _____ DATE: _____
<b>OPTION 3:</b> PARENT/GUARDIAN WILL PROVIDE EXPRESSED BREASTMILK	INITIALS: _____ DATE: _____	INITIALS: _____ DATE: _____
<b>OPTION 4:</b> BREASTFEEDING WILL OCCUR ON SITE	INITIALS: _____ DATE: _____	INITIALS: _____ DATE: _____

**BREASTFEEDING FRIENDLY CENTERS/PROVIDERS ARE ENCOURAGED!**

Many centers and providers now have designated space onsite for breastfeeding.  
Ask your center representative or day care home provider for details!

Federal regulations also require centers/providers participating in the CACFP to provide iron-fortified infant cereal and other foods when the child is developmentally ready.

PLEASE INDICATE PREFERENCES	BIRTH – 5 MONTHS	6 MONTHS – 11 MONTHS
<b>OPTION 1:</b> CENTER/PROVIDER OFFERED IRON-FORTIFIED CEREAL AND OTHER FOODS BASED ON THE CACFP MEAL PATTERN	INITIALS: _____ DATE: _____	INITIALS: _____ DATE: _____
<b>OPTION 2:</b> PARENT/GUARDIAN WILL PROVIDE CEREAL AND SOLID FOODS WHEN THE TIME IS APPROPRIATE	INITIALS: _____ DATE: _____	INITIALS: _____ DATE: _____

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**

1. THIS FORM MUST BE KEPT **CURRENT, ACCURATE AND ON FILE** FOR EACH INFANT ENROLLED IN CHILD CARE UNTIL THE INFANT REACHES 1 YEAR OF AGE OR IS NO LONGER ON BREASTMILK OR INFANT FORMULA.
2. BREASTMILK IS AN ACCEPTABLE MILK SUBSTITUTE FOR CHILDREN OF ANY AGE WITHIN THE CONTEXT OF THE CACFP.
3. AS SITUATIONS CHANGE, SUCH AS A MEDICAL AUTHORITY CHANGING AN INFANT’S FORMULA, A NEW FORM MUST BE COMPLETED.
4. IF THE PARENT/GUARDIAN DECLINES THE FORMULA AND THE CENTER/PROVIDER PROVIDES AT LEAST ONE **REQUIRED** MEAL AND/OR SNACK COMPONENT, THE MEAL OR SNACK MAY BE CLAIMED FOR REIMBURSEMENT.
5. IF THE PARENT/GUARDIAN DECLINES INFANT MEALS/SNACKS, THEY MAY NOT BE CLAIMED FOR REIMBURSEMENT.

*This institution is an equal opportunity provider.*