

**Child and Adult Care Food Program Survey
for Child Care Centers**

Please complete the following concerning your child and return immediately in the envelope provided.

1. **Child's Name:** _____
2. **Child Care Facility Name:** _____
3. **Date of Enrollment at child care (first day attended this facility):** _____
4. **Child's Birth Date:** _____
5. **Check the box next to the days of the week your child is in care at this facility:**

<input type="checkbox"/> Sunday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Saturday
<input type="checkbox"/> Monday	<input type="checkbox"/> Thursday	
<input type="checkbox"/> Tuesday	<input type="checkbox"/> Friday	
6. **Normal hours of care** (time child arrives at child care and time child is picked up):
Dropped off: _____ Picked up: _____
7. **Check the box next to the meals you expect your child to receive while in child care:**

<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Evening Snack
<input type="checkbox"/> Morning Snack	<input type="checkbox"/> Afternoon Snack	<input type="checkbox"/> Supper
8. **Is your child in care?** (check the appropriate box)

<input type="checkbox"/> All day	<input type="checkbox"/> Before School	<input type="checkbox"/> Evening
<input type="checkbox"/> Half Day Morning	<input type="checkbox"/> After School	<input type="checkbox"/> Overnight
<input type="checkbox"/> Half Day Afternoon	<input type="checkbox"/> Before and After School	

Parent's signature

Date

Optional information:

Phone number: _____

May we contact you for additional information if necessary? Yes No

Thank you for your time and assistance.

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Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health and Senior Services, Community Food and Nutrition Assistance, P.O. Box 570, Jefferson City, MO 65102, (1-800-733-6251). TDD users can access the preceding number by calling 1-800-735-2966. EEO/AAP services provided on a non-discriminatory basis.