

ENROLLMENT WORKSHEET THE PLANNING COUNCIL

130 W Plume Street

Norfolk

VA 23510

CHILD INFO:

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB: ____/____/____ Enrollment Date: ____/____/____

PARENT INFO:

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: Male Female Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____

Email: _____

FORMULA OPTION:

FOOD OPTION:

Parent Supplies Breast Milk or Formula
 Parent Accepts Provider-Supplied Formula

Parent Supplies Additional Food and Refuses Provider's Foods
 Provider Supplies Additional Foods When Developmentally Appropriate

Name of Parent Formula: _____

SCHOOL INFO:

ETHNICITY:

RACE:

School Age AM Kindergarten AM Headstart Hispanic/Latino American Indian / Alaska Native
 Home School PM Kindergarten PM Headstart Not Hispanic or Latino Asian
 All Year School All Day Kindergarten All Day Headstart Black or African American
 Native Hawaiian / Pacific Islander

School Name: _____

White

School Number: _____ School District: _____

School Depart Time: _____ : _____ AM / PM Return Time: _____ : _____ AM / PM

Days Attending School: MON TUE WED THU FRI

CHILD ATTENDANCE:

I anticipate the Days my child will participate will be: MON TUE WED THU FRI SAT SUN Days will vary

Drop Off Time _____ : _____ AM / PM Pick Up Time _____ : _____ AM / PM _____ Times will vary

I anticipate the Meals my child will participate will be: Breakfast AM Snack Lunch PM Snack Dinner Evening Snack

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 SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

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- FOR PROVIDER USE -

RELATIONSHIP TO PROVIDER

<input type="checkbox"/> Not related	Special needs Child	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Child will participate in CACFP	<input type="checkbox"/> Yes
<input type="checkbox"/> Related, non-resident	Special diet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Child Number: _____	
<input type="checkbox"/> Own Child	If special diet, explain			Child Group: _____	
<input type="checkbox"/> Helper's Child	_____				
<input type="checkbox"/> Foster Child	_____				

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