DEPARTMENT OF THE AIR FORCE
6TH AIR MOBILITY WING (AMC)
MACDILL AIR FORCE BASE, FLORIDA

MEMORANDUM FOR CHILD DEVELOPMENT CENTER HOURLY PARENTS

FROM: 6 FSS/FSFC

SUBJECT: Required Hourly Care Enrollment Forms for Child Care

1. Enrollment package and required documents must be completed and turned in prior to the provision of services. Failure to complete required documents can result in the refusal of child care. Required documents include:
    a. Registration Form (AF Form 1181): Please complete each line with correct information or write N/A if it does not apply to you. The emergency contact must be someone other than sponsor or spouse and be local to the area. The clerk will complete the immunization portion of the form. Please take your child's immunization record to the base immunization clinic. Inform them that your child is attending the CDC and you need a pink form. Bring the pink form back to the center with your completed package.
    b. Child Care Contract: Please carefully read each item, initial and sign bottom of form. A copy is provided for your recorded.
    c. Permission to be Photographed: Read and complete form.
    d. Information Sheet: Please read carefully and complete each line or write N/A if this does not apply to you
    e. USDA Meal Application Form: Please complete form. We must turn it in to the United States Department of Agriculture (USDA) Agency to receive funding for our meals.
    f. Infant Feeding Forms: Please complete if your child is between the ages of six weeks to 12 month.
2. To obtain care you must call and make a reservation no sooner than two weeks in advance. Reservations are available on a day-to-day basis based on the center's availability. Hourly care fees are $3.00 per hour and must be paid at the end of care day. We accept hourly care Monday –Friday 0730-1730.
3. For additional information or concerns, please call 828-3332 or come by the office and our Child Development Center personnel will make every effort to assist you.

Gail M. Mouse
GAIL M. MOUSE, Director
Child Development Center #1

AIR FORCE YOUTH FLIGHT PROGRAM PATRON REGISTRATION

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 8013; 44 USC 3101; EO 9397
PRINCIPAL PURPOSES: To provide Youth Flight Programs with authorization for medical treatment in emergency situations; authorization for field trips; identify children and sponsor, record required immunizations; record known allergies; record income data; record special needs requirements; and record special instructions.
ROUTINE USES: Form may be furnished to civilian doctors or hospitals in course of obtaining emergency medical attention for children. Information furnished may be disclosed, upon request, to other Federal, state or local governmental agencies in the pursuit of their official duties. Finally, it may be used for other lawful purposes including law enforcement and litigation.
DISCLOSURE IS VOLUNTARY: Failure to furnish information, including SSN, will result in denial of admission of child(ren) to Youth Flight Programs. SSN is used for positive identification of individuals and records.

CHILD'S NAME	SPONSOR *(Last, First, Middle Initial)*	SPOUSE *(Last, First, Middle Initial)*	FEES
HOME PHONE	RANK/GRADE	RANK/GRADE	DEROS/ID EXPIRES
ADDRESS	DUTY PHONE	DUTY PHONE	BRANCH OF SERVICE
	ORGANIZATION	EMERGENCY CONTACT	EMERGENCY PHONE
			HOSPITAL PHONE
MARITAL STATUS	SPONSOR'S SSN	SPOUSE'S SSN	PHYSICIAN'S NAME

VACCINE / DATE RECEIVED	BIRTH	2 MOS	4 MOS	6 MOS	12 MOS	15 MOS	18 MOS	4-6 YRS	11-12 YRS	14-16 YRS
Hepatitis B										
1st	Hep B-1									
2nd										
3rd		Hep B-2		Hep B-3					Hep B	
4th										
Diphtheria-Tetanus, Pertussis										
1st										
2nd										
3rd		DTP	DTP	DTIP	DTP			DTP OR DTAP	Td	
4th										
5th										
6th										
H.Influenzane type b										
1st										
2nd										
3rd		Hib	Hib	Hib	Hib					
4th										
Polio										
1st										
2nd										
3rd		OPV	OPV	OPV				OPV		
4th										
Measles, Mumps, Rubella										
1st					MMR			MMR OR MMR		
2nd										
Varicella Zoster Virus Vaccine										
1st						VZV			VZV	
2nd										

SEX *(X One)*		MALE	DATE OF BIRTH (Day, Month, Year)
		FEMALE	

I authorize emergency treatment for the children named hereon:

SIGNATURE	DATE (YYYYMMDD)

SPECIAL INSTRUCTIONS

E-MAIL ADDRESS:_____

Parent's Cell Phone Number:
Mother:_____
Father:_____

SPECIAL NEEDS CARE /CHRONIC ILLNESSES /ALLERGIES

OTHER IMMUNIZATIONS AS REQUIRED:

VACCINE TYPE:		DATE:	
VACCINE TYPE:		DATE:	
VACCINE TYPE:		DATE:	
VACCINE TYPE:		DATE:	

NAMES OF ADDITIONAL CHILDREN ENROLLED IN PROGRAM:

ADULTS AUTHORIZED TO SIGN CHILDREN IN / OUT

AUTHORIZATION FOR FIELD TRIPS

FAMILY INCOME *(Adjusted gross--most recent 1040)*:
PROVIDE ONLY IF REDUCED FEES ARE REQUESTED.

$_____ SINGLE / DUAL INCOME *(Circle One)* $_____

PARENT SIGNATURE

IT IS THE RESPONSIBILITY OF EACH SPONSOR TO ENSURE IMMUNIZATIONS AND EMERGENCY INFORMATION IS UP TO DATE. FAILURE TO UPDATE MAY RESULT IN REFUSAL OF SERVICE.

6th Force Support Squadron
MacDill Air Force Base
Airman and Family Services Flight

Emergency Contact Information

Section 1

I, _____, parent (legal guardian) of_____, authorize the 6th Force Support Squadron, MacDill Air Force Base Child Development Center Program personnel to accompany my child,_____to the designated emergency room in the event of a life threatening emergency requiring immediate medical attention. I also understand that my child's medical power of attorney will be activated during an emergency situation.

I have designated, _____to be my emergency contact and representative (at the hospital) in my absence, and they can be reached at _____ or_____.

Section 2

My child_____has the following medical condition _____ as indicated in his/her medical record he/she requires the following special medical care
_____
_____
_____
_____.

My child's care physician is_____; they can be contacted at_____.

Section 3

In the event it is required, my medical insurance is;
Insurance Carrier:_____
Sponsor:_____ Policy Number:_____
Contact Number:_____

_____
Parent's Signature

_____
Date

_____
Program Director's Signature

_____
Date

MACDILL AIR FORCE BASE CHILD DEVELOPMENT CENTER 1
HOURLY RESERVATION, CANCELLATION AND FEE POLICY CONTRACT

Agreement executed at MacDill AFB, Florida this day____ of this month _____of year 20___, by and between (parent) _____of (child) _____, hereinafter referred to as the parent and the MacDill AFB Child development center 1, hereinafter referred to as the CDC 1. For and in consideration of the conditions and agreements hereinafter set forth, the parties agree as follows:

PARENTS PLEASE READ AND INTIAL EACH ITEM BELOW.

1. Hourly Reservations:
   _____a. Hourly care reservations can be made at either CDC #1 or # 2, for children ages six months to five years (not in elementary school) between 0730 and 1730 hours.
   _____b. Reservations are booked on a first-come, first-served basis and may be requested up to two weeks in advance. If space is unavailable at the time of request, patrons may request to put on a waiting list and will be notified if an opening occurs.

2. Arrival and Departure Limitations and Extensions:
   _____a. A reservation will be guaranteed for 30 minutes after the beginning of the reserved time. Patrons will be charged for the entire reserved time. Reservations cannot be guaranteed after 30 minutes.
   _____b. Patrons must designate a time the reservation will end and then they must arrive on time. Late patrons will be charged a late fee (see fees). Failure to pick up your child on time twice within 120 days will result in a loss of reservation privileges.
   _____c. Patrons may request to have the reservation extended. These requests must be made at least one hour prior to the end of the reserved time and will be granted on a space-available basis. If the requested extension is denied, patrons must arrive on time.

3. Cancellations:
   _____a. Patrons are required to cancel reservations at least two hours prior to the reserved time or by 0830, Monday through Friday.
   _____b. Failure to cancel reservations will result in the following:
      1. First "no show" – no charge; reminded of the policy.
      2. Second "no show" – charged for reserved time; reminded of policy.
      3. Third "no show" – charged for reserved time; loss of reservation privileges.

4. Fees and Charges:
   _____a. Hourly child care fee is established locally and must be at least as much as the hourly rate for the highest category of parent fees.
   _____b. There is no charge for meals and snacks. Parents are required to fill out the meal income application since the CDC participates in the USDA Child Care Feeding Program.
   _____c. There is a late pick up fee of $5.00 for every fifteen minutes or portion of thereof which exceeds the reserved time. Payment is due at the time of pick-up. Failure to pay the late fee will result in notification of the sponsor's commander.

Both of the undersigned parties have fully read the foregoing document, acknowledge their understanding of and agree with the terms and conditions set forth.

ALL THREE SIGNATURES REQUIRED

_____ _____
Sponsor's Signature Date

_____ _____
Spouse's Signature Date

_____ _____
CDC Representative Date

MACDILL AIRMAN AND FAMILY SERVICES FLIGHT
PERMISSION TO BE PHOTOGRAPHED

Child's Name: _____

Program: _____CDC 1 _____ CDC 2 _____ School Age Program

Throughout the course of the program, there may be occasions when your child could be photographed, i.e., classroom activities, special events for the base newspaper, etc. Please sign below giving your permission for your child to be photographed.

_____ I DO _____ I DO NOT give permission for my child to be photographed while attending the MacDill Airman and Family Services Flight Programs.

Parent's Signature & Date: _____

(Permission to be photographed valid one year from signature)

FILE IN CHILD'S RECORD

MACDILL AFB CHILD DEVELOPMENT CENTER
ENROLLMENT INFORMATION

Your child's care during the day is a responsibility we share. The following information will be used to place your child in the appropriate classroom. It will also help the staff know your child better.

Child's Full Name_____Date of Birth_____

What name do you want us to use for your child?_____

Father's Name_____Mother's Name_____

Who lives in the house with your child (include children and adults)?

NAMES	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

What language is spoken at home?_____

Does your family have any religious, cultural or dietary customs that may affect your child at the center?_____

Please specify?_____

Does your child have any identifying marks (birthmarks/scars)?_____
Location_____ Size_____

What words does your child use for: Urination?_____Bowel Movement?_____

What are his/her favorite foods (include liquids)?_____

Does your child take a naps at home?_____How long?_____How many?_____

Does your child sleep with a special blanket?_____(Children may bring one to use at naptime.)

Does your child sleep in a crib?_____ Bed?_____ What time does your child generally go to bed?_____

Has your child had a serious illness or injury?_____ Please specify?_____

Does your child seem to see and hear all right?_____

Does your child seem to learn things as quickly as other children his/her age?_____

Can people outside of your family understand what your child says?_____

Does your child verbalize his/her needs?_____

Has your child been in day care before? If so, where and what age?_____

What fears does your child have?_____

What makes your child angry/upset?_____

How would you describe your child's temperament/nature?_____

How would you discipline your child?_____

CHILDREN SIX MONTHS TO TWO YEARS:

Is your child still in diapers?_____Pull-ups_____Potty-trained_____In the process of potty-training?_____

Does your child use a pacifier?_____If so, when?_____

Does your child use a bottle?_____ If so, when?_____

Does your child use a cup?_____If so, when?_____

Does your child eat jar baby food?_____ If so what type (strained, junior, etc.)_____

Does your child eat table food?_____Does your child feed him/herself?_____Use a spoon?_____

Does your child sit-up by him/herself?_____

If any, what words does your child use?_____

CHILDREN THREE TO FIVE YEARS:

Does your child go to the bathroom independently?_____

Does he/she have frequent toileting accidents? Daytime_____Nighttime_____

****

Is there anything else you would like us to know about your child or family to better serve your needs?_____

_____

_____ _____

Signature Date

FLORIDA DEPARTMENT OF HEALTH

CHILD CARE FOOD PROGRAM
FREE AND REDUCED-PRICE MEAL APPLICATION

To apply for free and reduced price meals for your child, read the instructions and complete this form. Sign your name, date and return the application to Child Development Center _____. If you need assistance filling out this form, call this number: 813-828-3332 _____.

PART 1 – INFORMATION ON CHILD:

Child's Name: _____ _____ _____
Last Name First Name Date of Birth

MacDill Child Development Center
8706 Hangar Loop Drive
MacDill AFB, FL 33621

ICC: _____

PART 2 – HOUSEHOLDS RECEIVING FOOD ASSISTANCE PROGRAM OR TANF BENEFITS: Complete this part and Part 5.

Food Assistance Program Case Number: | | | | | | | | | | | | TANF Case Number: | | | | | | | | | | | |

PART 3 – HOUSEHOLDS WITH A FOSTER CHILD: Complete this Part and Part 5. If this is a foster child, check this box ☐
List the child's monthly personal use income $_____ Write "0" if the child has no personal use income.

PART 4 – ALL OTHER HOUSEHOLDS: If you gave a Food Assistance Program or TANF number or if this is an application for a foster child then skip to Part 5. Otherwise, complete this part and Part 5.

NAMES	INCOME AMOUNT / FREQUENCY Example: $100 / month or $100 / twice a month or $100 / biweekly or $100 / week				
List the Names of Everyone in Your Household (include child listed in Part 1 above)	Gross Earnings (Before Deductions) If self-employed, list net income	Welfare, Child Support, Alimony	Pensions, Retirement, Social Security	All Other Income	Check If **No Income**
(Example) Jane Smith	*$ 199 / week*	*$ 149 / biweekly*	*$ / ___*	*$ 99 / month*	☐
1. _____	$ ___/___	$ ___/___	$ ___/___	$ ___/___	☐
2. _____	$ ___/___	$ ___/___	$ ___/___	$ ___/___	☐
3. _____	$ ___/___	$ ___/___	$ ___/___	$ ___/___	☐
4. _____	$ ___/___	$ ___/___	$ ___/___	$ ___/___	☐
5. _____	$ ___/___	$ ___/___	$ ___/___	$ ___/___	☐
6. _____	$ ___/___	$ ___/___	$ ___/___	$ ___/___	☐

PART 5 – SIGNATURE AND SSN: An adult household member must sign the application before it can be approved.

PENALTIES FOR MISREPRESENTATION: I certify that all information on this application is true and correct and that all income is reported. I understand that this information is being given for the receipt of Federal funds; that institution officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Social Security Number |__|__|__| - |__|__| - |__|__|__|__|
Write **NONE** if you don't have a Social Security Number

_____
(Signature of Adult Household Member) Home Phone No. _____ Work Phone No. _____
Date Signed _____ Home Address _____ Zip Code _____

PART 6 (Optional) -

RACIAL IDENTITY OF CHILD
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White

ETHNIC IDENTITY OF CHILD
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Privacy Act Statement: Section 9 of the National School Lunch Act requires that, unless you list a current Food Assistance Program or TANF case number or are applying for a foster child, you must include the social security number of the adult household member signing the application or indicate that the household member does not have a social security number. Provision of a social security number is not mandatory, but if a social security number is not given or an indication is not made that the signer does not have such a number, the application cannot be approved. The social security number may be used to identify the household member in carrying out efforts to verify the correctness of information stated on the application. These verification efforts may be carried out through program reviews, audits, and investigations and may include contacting employers to determine income, contacting a Food Assistance Program or welfare office to determine current certification for receipt of Food Assistance Program or TANF benefits, contacting the state employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported.

For Contractor Use Only:
☐ Food Assistance Program/TANF household ☐ Foster Child ☐ Zero Income Application – Temporary Free Until _____ (evaluate every 45 days)

Total Household Size:_____ Total Household Income: $_____ Weekly / Biweekly / Twice a Month / Monthly / Annually
(Circle one of the above)

Note: If different income frequencies are listed, convert all income to an annual amount.
Annual Income Conversion: Weekly x 52, Biweekly x 26, Twice a Month x 24, Monthly x 12

Eligibility Determination: ☐ Free ☐ Reduced ☐ Non-needy
Reason for Non-needy Status: ☐ Income too High ☐ Incomplete Application ☐ Other (Reason)_____

Signature of Determining Official:_____ Date Signed:_____

APPLICATION INSTRUCTIONS

IF ANY MEMBER OF YOUR HOUSEHOLD RECEIVES FOOD ASSISTANCE PROGRAM OR TANF BENEFITS, FOLLOW THESE INSTRUCTIONS:

Part 1: Print the name and date of birth of the child you are applying for. Print the name and address of the child care center the child attends, if not already pre-printed.
Part 2: List the current Food Assistance Program (formerly known as the Food Stamp Program) or TANF (Temporary Assistance for Needy Families) case number. The case number is on your letter of eligibility; it is not the number on your EBT card.
Skip Parts 3 and 4.
Part 5: An adult household member must sign the form, but a social security number is not necessary. Complete the address and phone number fields and date the form.
Part 6: You are not required to answer this question. However, providing this information will help ensure equal access to the Child Care Food Program.

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS:

Part 1: Print the name and date of birth of the child you are applying for. Print the name and address of the child care center the child attends, if not already pre-printed.
Skip Part 2.
Part 3: Check the box and list the child's personal use monthly income. Write "0" if the the child does not get personal use income.

- "Personal use" income is a) money given by the welfare office identified by category for the child's personal use, such as for clothing, school fees, and allowances; and/or b) all other money the child receives, such as money from his/her family and money from the child's full-time or regular part-time jobs.
- In certain cases, foster children are eligible for free or reduced-price meals regardless of the income of such household with whom they reside and households wishing to apply for such benefits for foster children should contact us.

Skip Part 4.
Part 5: A foster parent or other official representing the child must sign the form, but a social security number is not necessary. Complete the address and phone number fields and date the form.
Part 6: You are not required to answer this question. However, providing this information will help ensure equal access to the Child Care Food Program.

ALL OTHER HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

Part 1: Print the name and date of birth of the child you are applying for. Print the name and address of the child care center the child attends, if not already pre-printed.
Skip Parts 2 and 3.
Part 4:

(1) Write the names of everyone in your household, whether they receive income or not. Include yourself, the child you are applying for, all other children, your spouse, grandparents and other related and unrelated people in your household. Use another piece of paper if you need more space.
(2) Write the amount of income each household member regularly receives, before taxes or anything else is taken out, and how often it is received. List income in the appropriate column(s) to designate the source of the income, such as earnings, welfare, pensions, and other income (**refer to examples below for types of income to report**). If any amount(s) received during the last month was more or less than usual, write that person's usual income.
(3) For any person with no income, including children, check the "No Income" box.

Part 5: An adult household member must sign the application and give his/her social security number (or write NONE if s/he doesn't have a social security number).
Part 6: You are not required to answer this question. However, providing this information will help ensure equal access to the Child Care Food Program.

INCOME TO REPORT

Earnings from Employment
Wages/salaries/tips
Strike benefits
Unemployment compensation
Worker's compensation
Net income from self-owned business or farm

Welfare/Child Support/Alimony
Public assistance payments
Welfare payments
Alimony/child support payments

Pensions/Retirement/Social Security
Pensions
Supplemental security income
Retirement income
Veteran's payments
Social security

Military Households
All cash income for off base commercial/private housing allowances, excluding the Military Housing Privatization Initiative and Family Subsistence Supplemental Allowance (FSSA)
All cash income for uniform allowances
Does not include "in-kind" benefits NOT paid in cash (base housing, clothing, food, medical care, etc.)
All cash income made available to the household, except for combat pay

Other Income
Disability benefits
Cash withdrawn from savings
Interest/dividends
Income from estates/trusts/investments
Regular contributions from persons not living in the household
Net royalties/annuities/net rental income
Any other income

FLORIDA DEPARTMENT OF HEALTH

Child Care Food Program

Child Participation Form

Name of Child: _____ Name of Facility: _____

Dear Parent:
Please fill out the following information so that your child may participate in the Child Care Food Program, which reimburses child care providers for serving nutritious, well-balanced meals to children in child care.

If child care hours are the same every day, please complete this chart.

Day	Normal Hours in Care	Meals Normally Received While in Care
Mon – Fri	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐

OR

If child care hours are <u>not</u> the same every day, please complete this chart.

Monday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
Tuesday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
Wednesday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
Thursday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
Friday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
Saturday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐
Sunday	a.m. _____ p.m. to a.m. _____ p.m.	Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Eve Snack ☐

☐ **Check here if your child has no regularly scheduled hours of care**

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____ Phone Number: _____

I-108-01

CCFP Infant Feeding Form

CHILD CARE PROVIDER USE ONLY – Complete this shaded section before distributing to parents			
Child Care Provider Name:	MacDill Child Development Center		
Iron-fortified Milk based formula offered:	ENFAMIL PREMIUM	Iron-fortified Soy based formula offered:	PROSOBEE

Parents: Participation in the Child Care Food Program ensures that healthy meals are served to your baby while in child care. To help provide the best nutritional care for your baby, please complete the following information:

Baby's Name: **Baby's Birth Date:**

Place a check mark (✓) by each of the following that apply for your baby:

My baby is:
- ☐ 0 to 3 months old
- ☐ 4 to 7 months old
- ☐ 8 to 11 months old

My baby is:
- ☐ Breastfed
- ☐ Breast and formula fed
- ☐ Formula fed

My baby can:
- ☐ Drink from a cup
- ☐ Eat from a spoon
- ☐ Sit alone without support

My baby is eating:
- ☐ Infant cereal
- ☐ Jar foods
- ☐ Table foods

Other things we should know about feeding your baby: (For example – feeding schedule, allergies, special feeding needs)

I understand that the child care provider will supply the above iron-fortified formulas for infants according to the Child Care Food Program requirements. ***Note: Child care providers may request parents to supply clean, sanitized and labeled bottles on a daily basis.**

If you *formula-feed* your baby, place a check mark (✓) by only ONE of the following:

☐ I prefer to have the child care provider supply formula. **OR** ☐ I will supply my own formula.

If you *breastfeed* your baby, place a check mark (✓) by only ONE of the following:

☐ I will supply expressed (pumped) breastmilk. **OR** ☐ I will supply expressed (pumped) breastmilk and supply my own formula to supplement as needed.

OR ☐ I will supply expressed (pumped) breastmilk and have the child care provider supply formula as needed.

I understand the child care provider will supply infant cereal and baby food for infants 4 months and older according to Child Care Food Program requirements.

Place a check mark (✓) by only ONE of the following:

☐ I prefer to have the child care provider supply infant cereal and baby food. **OR** ☐ I will supply my own cereal and baby food.

This facility 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 CCFP. I also understand that all bottles of breastmilk or formula and containers of food that I prepare and supply for my infant **must be labeled with my baby's name, and date and time of bottle preparation.**

Parent Signature ***Date***