DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

Infant Formula and Food Notification Form

Infant's Name: _____ **DOB:** _____

Child Care Provider: _____

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

Your child's care provider participates in the Child and Adult Care Food Program (CACFP). The CACFP is administrated by the District of Columbia Office of the State Superintendent of Education and is funded by the United States Department of Agriculture (USDA). The CACFP subsidizes the cost of the healthy meals prepared and served to your infant while in care. Your provider follows the USDA Meal Pattern Requirements for Infants (see below), as age- and developmentally-appropriate for your baby.

As a participant in the CACFP, your provider must offer formula and meals to all enrolled infants and children.

USDA Meal Pattern Requirements For Infants			
Age	**Breakfast**	**Lunch or Supper**	**Snack**
0 - 5 months	4-6 fluid ounces formula *or* breast milk		4-6 fluid ounces formula *or* breast milk
6 - 11 months	6-8 fluid ounces formula *or* breast milk AND 0-2 Tbsp fruit *or* vegetable *or* both AND 0-4 Tbsp iron fortified infant cereal, meat, fish, poultry, egg yolk, cooked dry beans or peas; *or* 0-2 oz cheese; *or* 0-4 oz (volume) cottage cheese; *or* 0-4 oz or 1/2 cup of yogurt, or a combination of the above		2-4 fluid ounces formula *or* breast milk AND 0-2 Tbsp fruit *or* vegetable *or* both AND ½ slice bread; *or* 0-2 crackers; *or* 0-4 Tbsp infant cereal or ready-to-eat breakfast cereal

PARENT FORMULA REQUEST

USDA supports and encourages mothers to continue breastfeeding when returning to work or school. *You have the option to breastfeed your infant at the center, bring your own formula or breast milk, or use the provider-supplied formula.* The provider offers the formula listed below.

Name of provider-supplied formula: _____

Do you accept or decline the formula supplied by your provider? *(Circle one)* **ACCEPT** **DECLINE**

If you DECLINE, list the brand of formula you will provide, or breast milk, or identify if you will breastfeed on site: _____

PARENT FOOD REQUEST

When your infant is 6 months and/or developmentally ready to eat solid foods, do you accept or decline the provider-supplied food?

(Circle one) **ACCEPT all foods** **DECLINE all foods**

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Guardian: _____

Please check the back of this form for the center to know which food items to serve to your baby.

First Foods Check-In

Age of Infant: _____

Developmental Readiness Indicators

Indicators from HealthyChildren.org by the AAP

Can your infant sit up with little or no help? *(in a high chair or feeding seat with good head control)*	Yes:		No:	
Does your infant open her mouth when food comes their way? *(tracking food on a spoon, reaching for food, eager to be fed)*	Yes:		No:	
Can your infant move food from a spoon into their mouth/throat? *(swallow without choking or gagging, little to no dribbling)*	Yes:		No:	
Has your infant doubled their birth weight? *(weighs at least 13 pounds)*	Yes:		No:	
Have you introduced solid foods to your infant?	Yes:		No:	

If yes, select components and list which food items you have introduced to your infant?

Components	Check below	Food items introduced
Iron-fortified infant cereal and/or grains		
Meat/meat alternates		
Fruits		
Vegetables		

If yes, are there any foods that you do not want the institution to serve your infant? For example: beef, carrots, strawberries.

Components	Check below	Food items to avoid
Iron-fortified infant cereal and/or grains		
Meat/meat alternates		
Fruits		
Vegetables		

Comments: