NEW YORK STATE DEPARTMENT OF HEALTH Child and Adult Care Food Program

Parent or Guardian completes form				Provider #3329
Name of Day Care or Owner/OperatorLittle Leader	rs Childcare Inc.			
On-Site Provider (if different)Subha Ahmed				
Child's Name	Child #	#	DOB	Male
Child's Name	Child #	#	DOB	Male
Child(ren)'s Ethnic Information (Choose one option p	er child)			
☐ Hispanic or Latino	☐ Not Hispanic o	or Latino		
Child(ren)'s Racial Information				
☐ American Indian or Alaskan Native	☐ Asian		☐ Native H	Hawaiian or other Pacific Islander
White Primary language spoken at home		African American		
Check if any of these apply ☐ Provider's Resident Child ☐ Child is related to	to Provider 🔲 C	Child of Migrant Fa	ırm Worker 🔲 Spec	ial Needs
HOURS/DAYS/MEALS Date Care Begins				
Child #Time Care Begins	Time	Time Care Ends		
Child #Time Care Begins		Time Care Ends		
Days child normally receives care	☐ Tues ☐ W	Ved 🔲 Thui	ırs 🔲 Fri	☐ Sat ☐ Sun
Meals child normally receives in care Breakfast] AM Snack 区 L₁	unch 🗵 PM	Snack Supper	☐ LN Snack
		Care Begins8am	• • • • • • • • • • • • • • • • • • • •	Time Care Ends6pm
Does child(ren) attend school Yes	☐ No Name	e of School		
Does child receive care on non-school days?	☐ Yes ☐ N	10		
INFANT FEEDING STATEMENT (must be completed for	r any child less that	n one year of age))	
☐ The Parent will supply breastmilk or formula	□ T/	☐ The Parent will supply ALL infant's food		
☐ The Provider will supply formula ☐ The Provider will supply infant's food				
CONTACT INFORMATION FOR PARENT/GUARDIAN -	- to be completed	by Parent/Guardia	an	
Parent/Guardian's Name Email Address				
Parent/Guardian's Name		Email Address _		
Home Address				
Home Phone Number		Work/Cell Phon	ie Number	
Parent/Guardian Signature				
	FOR SPON	NSOR USE ONLY		
Date Enrollment Begins Date Enrollment Expires Child Enrollment Approved				
Emergency Placement				INITIALS
Emergency Placement		PROVIDER NAME/E	DATES	
PROVIDER NAME/DATES				

This institution is an equal opportunity provider.