

RIVER VALLEY FAMILY DAY CARE FOOD PROGRAM

REACTIVATION FORM

Provider's Name _____

(Please Print)

Child's Name _____

(Please Print)

Child's # _____ Child's Birthdate _____ Date of Reactivation _____

SCHOOL INFORMATION

_____ School age _____ Home school _____ AM Head start _____ PM Head Start
_____ Infant _____ Kindergarten _____ All Day Head Start

PAYMENT

_____ Private _____ DHS _____ Own

SPECIAL NEEDS:

Special Needs Child _____ Yes _____ No
Special Diet _____ Yes _____ No

SCHEDULE

I anticipate the Days my child could be at the provider's home: _____ Mon _____ Tues
_____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun

Earliest possible drop off time: _____:_____ AM PM **Latest** possible pick up time
_____:_____ AM PM

I anticipate the meals my child could participate in will be: _____ Breakfast _____ AM
Snack
_____ Lunch _____ PM Snack _____ Supper _____ EV Snack

PARENT INFORMATION

Parent's Name _____

(Please Print)

Address _____

(Please Print)

City _____ State _____ Zip Code _____ Phone _____

Place of employment _____ Work Phone _____

Parent's signature _____

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