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_____________________________________Date_________________________

The date parent signs need to be the date the reactivation takes effect.

This institution is an equal opportunity provider