www.HFS-CACFP.org
402-451-6244
6720 N. 30th Street
Omaha, NE 68112

Infant Formula 6 weeks to 4 months

Provider Name:____

Infant Name:____________________________Date of Birth___________________

Formula Offered by Facility____

__________I accept the above named formula for my infant.

__________I decline the above named formula for my infant.

____
Parent's Signature

____
Date

__________I decline my provider's meal pattern and will provide all of the food for my infant's meals.

____
Parent's Signature

____
Date