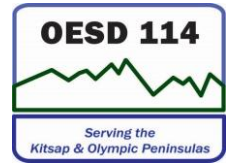




# Olympic Educational Service District 114

105 National Avenue North, Bremerton, Washington 98312  
(360) 478-6887 • 1-800-201-1300 • FAX (360) 405-5808



## INFANT MEAL OFFER FORM—Early Head Start

Site: \_\_\_\_\_

In order to claim infants on the Child and Adult Care Food Program, USDA requires us to offer at least one approved iron-fortified infant formula for participating infants under one year of age.

As a parent/guardian, you may decline the offered formula and supply another approved infant formula.

Please note that some specialized formulas may require a note from your doctor.

**Name of participating infant under 1 year of age:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

Please choose from the following:

- I will provide breast milk.
- I **accept** the following formula provided by OESD 114 Early Head Start:
  - Similac Advance (milk based formula)
  - Enfamil ProSobee (soy based formula)
- I use the following bottle type/nipple size: \_\_\_\_\_.
- I **decline** the offered formula and choose to provide the following approved formula \_\_\_\_\_.
- I **decline** the offered formula and will provide a non-approved or specialized formula.  
*I will provide a note from a recognized medical authority for this formula.*

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

My infant is developmentally ready to be served semi-solid/solid foods, starting at \_\_\_\_\_.  
(list age or date to begin)

- I **accept** the semi-solid/solid foods offered for my infant.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_