

MONTHLY MEAL COUNT AND ATTENDANCE RECORD

PAGE	 of	

MONTH/YEAR:

PROVIDER NAME:

5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 TOTAL Child Information TIER Meals NAME: Breakfast **AM Snack** Lunch DOB: **PM Snack Hours of Care:** Supper **Late Night Snack** NAME: Breakfast **AM Snack** Lunch DOB: PM Snack **Hours of Care:** Supper Late Night Snack NAME: Breakfast **AM Snack** Lunch DOB: **PM Snack Hours of Care:** Supper Late Night Snack NAME: Breakfast **AM Snack** Lunch DOB: **PM Snack Hours of Care:** Supper Late Night Snack NAME: Breakfast AM Snack Lunch DOB: PM Snack Hours of Care: Supper Late Night Snack NAME: Breakfast **AM Snack** Lunch DOB: PM Snack **Hours of Care:** Supper Late Night Snack

	CACFP Child and Adult Care Food Program New York State Department of Health
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Late Night Snack

PROVIDER NAME:_

MONTHLY MEAL COUNT AND ATTENDANCE RECORD

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MONTH/YEAR:

Child Information		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL	Tier
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COMMENTS.	Provider Signature: I certify that the information on this form is true and correct to the best of my knowledge. I understand this information is being given in connection with receipt of federal funds and that deliberate misrepresentation may result in my being named seriously deficient and my termination/disqualification from CACFP participation.	
	X. DATE:	
	RECORD REVIEWED BY:	