

MONTHLY MEAL COUNT AND ATTENDANCE RECORD

PROVIDER NAME: _____

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			
NAME: DOB: Hours of Care:	Breakfast																																				
	AM Snack																																				
	Lunch																																				
	PM Snack																																				
	Supper																																				
	Late Night Snack																																				
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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: _____ DATE: _____