CHILD AND ADULT CARE FOOD PROGRAM - CHILD DEVELOPMENT COUNCIL (607) 273-0259

Pg.___ of____

Name:_____ Capacity:_____ Month/Year:_____ Phone #:(___) ___-_____

OFFICE USE
TOTAL:

Each child must be marked for attendance on all days they attended your program.

Name of Child:	Meal	Time	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		Attn.	Meals
1)	**ATTENDANCE**																																			
Circle all that apply:	Breakfast																																	B		
School age	AM Snack																																	AM		
Infant: DOB__/__/__	Lunch																																	L		
	PM Snack																																	PM		
Provider's own No Meals	Supper																																	S		
Income eligible Foster	Evening Snack																																	E		
2)	**ATTENDANCE**																																			
Circle all that apply:	Breakfast																																	B		
School age	AM Snack																																	AM		
Infant: DOB__/__/__	Lunch																																	L		
	PM Snack																																	PM		
Provider's own No Meals	Supper																																	S		
Income eligible Foster	Evening Snack																																	E		
3)	**ATTENDANCE**																																			
Circle all that apply:	Breakfast																																	B		
School age	AM Snack																																	AM		
Infant: DOB__/__/__	Lunch																																	L		
	PM Snack																																	PM		
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4)	**ATTENDANCE**																																			
Circle all that apply:	Breakfast																																	B		
School age	AM Snack																																	AM		
Infant: DOB__/__/__	Lunch																																	L		
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5)	**ATTENDANCE**																																			
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