

# CHILD AND ADULT CARE FOOD PROGRAM FAMILY DAY CARE MEAL COUNT & ATTENDANCE RECORD

**PROVIDER NAME** \_\_\_\_\_ **MONTH OF:** \_\_\_\_\_ **# OF OPERATING DAYS** \_\_\_\_\_

**Meal Service Hours: Breakfast:      AM Snack:      Lunch:      PM Snack:      Dinner:      Eve. Snack:**

ENROLLED CHILD	Allergies (**AS) Y / N		Age		Allergies (**AS) Y / N		Age		Allergies (**AS) Y / N		Age		Allergies (**AS) Y / N		Age														
	A*	B	A	L	P	D	E	A*	B	A	L	P	D	E	A*	B	A	L	P	D	E	A*	B	A	L	P	D	E	
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																													
<b>TOTAL</b>	A*	B	A	L	P	D	E	A*	B	A	L	P	D	E	A*	B	A	L	P	D	E	A*	B	A	L	P	D	E	

### CERTIFICATION

I HEREBY CERTIFY that I am not participating in the Child and Adult Care Food Program under any other sponsoring organization. I further CERTIFY that all of the above information is true and correct. I understand that this information is being given in connection with the receipt of federal funds that Department officials may, for cause, verify information and that deliberate misrepresentation may subject me to prosecution or civil action under application state and criminal status. The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: [program.intake@usda.gov](mailto:program.intake@usda.gov). This institution is an equal opportunity provider.

**Provider Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

PROVIDER NUMBER		FOR PROVIDER USE	BREAKFAST	AM	LUNCH	PM	DINNER	EVE
		<b>MEAL TOTALS</b>						
FOR SPONSORING ORGANIZATION OFFICE USE ONLY								
HOME TYPE	TOTAL ATTENDANCE	ADA	BREAKFAST	AM	LUNCH	PM	DINNER	EVE
I								
II H								
II L								
M								
			<b>TOTAL</b>					