MISSION C.I.S.D. CHILD NUTRITION PROGRAM

SACK BREAKFAST REQUEST FORM 2017-2018

Date Submitted:_____ ***CNP OFFICE USE ONLY*** _____ ***Site*** _____ ***CK***

PLEASE SUBMIT ONE COPY TO CNP OFFICE SEVEN (7) DAYS IN ADVANCE TO ASSURE DELIVERY. ORDERS RECEIVED LESS THAN (7) DAYS PRIOR TO EVENT MAY NOT BE APPROVED.

CNP Office: 323-3800 CNP Fax: 323-8176

Person Submitting Request:_____ Grade:_____

School:_____ Date sack breakfast needed:_____

Deliver breakfasts to room #:_____ / Time:_____

OR

Pick up in the cafeteria:_____ / Time:_____

(Student meals are at no charge when school is in session. Otherwise breakfast meals are $2.25 including Saturdays)

Please send an attendance roster of your class to the Child Nutrition Program Office on day of event for T.D.A. reporting purposes. Please direct any questions to 323-3800.

Reason for Sack Breakfast Request:_____

Number of Sack Breakfast Needed:

Students:_____ **(attendance roster required)**

_____

Purchase Order # is required at time of request

Adults:_____ **$2.25 each** Total for adult meals due: $_____

(<u>One adult meal at no charge allowed per classroom</u> when school is in session) (No free meals on Saturdays)

(CNP Office will complete this section)

Fruit Juice - <u>Choose One:</u>

_____ Fruit Punch Juice _____ Apple Juice _____ Grape Juice

****All Sack Breakfasts include ½ pint of Milk:** **Indicate amount requested of each below**

_____ Skim Milk _____ Milk 1 % _____ Chocolate Milk

*****Meals cancelled the same day or after noon the day before will be charged to the person signing this request at $2.25 each meal.***

Teacher Signature:_____ _____ Date

Approved by:_____ _____ Date

Principal

_____ _____ Date

Child Nutrition Program Director

*****Milk and/or meal must be transported in ice chests. Ice is provided at no charge.***