

MISSION C.I.S.D. CHILD NUTRITION PROGRAM
SACK LUNCH REQUEST FORM 2016-2017

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: _____

Deliver lunches to Room #: _____

or

Pick up in the cafeteria: _____

Date Sack Lunches Needed: _____

Time Needed: _____

(Student meals are at no charge when school is in session. Otherwise lunch meals are \$3.75 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 Lunch Request: _____

Number of Sack Lunches Needed:

Students: _____ (attendance roster required)

Purchase Order # is required at time of request

Adults: _____ \$3.75 each

Total for adult meals due: \$ _____

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

For CNP office use only.

****Meals cancelled the same day or after noon the day before will be charged to the person signing this request at \$3.75 each meal.**

Teacher Signature: _____

_____ Date

Approved by: _____

Principal

_____ Date

Child Nutrition Program Director

_____ Date

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