

MENU FORM (return monthly with your monthly meal count form).

MONTH	Provider's Name:	Provider's Address:
CALENDAR DATE:		
fluid milk		
fruit, vegetable or full strength juice		
cereal and/or bread equivalent		
other food (optional)		
Choose two of these four:		
fluid milk		
fruit, vegetable or full strength juice		
bread, cereal or equivalent		
meat and/or alternate		
fluid milk		
meat and/or alternate		
vegetable or fruit		
vegetable or fruit		
bread or equivalent		
other food (optional)		
Choose two of these four:		
fluid milk		
fruit, vegetable or full strength juice		
bread, cereal or equivalent		
meat and/or alternate		
fluid milk		
meat and/or alternate		
vegetable or fruit		
vegetable or fruit		
bread or equivalent		
other food (optional)		

MONTH

Provider's Name:

Provider's Address:

BREAKFAST

AM SNACK

LUNCH

PM SNACK

SUPPER

Mail to: NEMO Community Action Agency
 P.O. Box 966
 Kirksville, MO 63501
 Attn: Child Care Food Program

