

# NUTRITION PLUS, INC.

MONTH \_\_\_\_\_, 20 \_\_\_\_\_

PROVIDER \_\_\_\_\_

2ND PROVIDER Name \_\_\_\_\_

## ATTENDANCE & MEAL COUNT

SCHOOL CLOSED DAYS \_\_\_\_\_

HOLIDAYS \_\_\_\_\_

C\* Child's Full Name \_\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Arrives: \_\_\_\_\_  
 Leaves: \_\_\_\_\_  
 Days in care M T W Th F Sa Su

A	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	A		
B																																	B	
S																																		S
L																																		L
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Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Arrives: \_\_\_\_\_  
 Leaves: \_\_\_\_\_  
 Days in care M T W Th F Sa Su

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**\*Categories:**

I - Infant - birth -12 months

P - Preschool - under 5 years  
 S - School age

I certify that the information on this form is true and correct to the best of my knowledge. I understand this information is being given in connection with the receipt of federal funds and that deliberate misrepresentation may subject me to prosecution under applicable state and federal criminal statutes.

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Phone Number \_\_\_\_\_