*Cereal/Granola/Oatmeal Manufacturer: _____

* Yogurt Brand and Flavor: _____

* Milk Substitute (Request form approved & in office)

Brand of soy milk: _____

*Milk Key / Legend:

MENU

NUTRITION FIRST
P.O. Box 2316
Salem, OR 97308-2316
(503) 581-7563 or 1-800-288-6368

"This institution is an equal opportunity provider"

Name: Month:

		DATE:	DATE:	DATE:	DATE:	DATE:
Breakfast	Fruit/Veg	☐	☐	☐	☐	☐
Time served	Grains/Meat					
_____	Milk					
AMS		☐	☐	☐	☐	☐
Time _____						
Lunch	Meat/Alt	☐	☐	☐	☐	☐
Time served	Vegetable					
_____	Fruit/Veg					
	Grains					
	Milk					
PMS		☐	☐	☐	☐	☐
Time _____						
Dinner	Meat/Alt	☐	☐	☐	☐	☐
Time served	Vegetable					
_____	Fruit/Veg					
	Grains					
	Milk					
LNS		☐	☐	☐	☐	☐
Time _____						

NOTE: Please write "HM" next to homemade soups, stews, casseroles, etc.

The information submitted is accurate in all respects. I understand that this information is given in connection with the receipt of Federal funds and that deliberate misrepresentation may result in State or Federal Prosecution.

☐ I certify all grain products are enriched or whole grain-rich

Please sign and date:_____

*Please check box