

# CHILD MENU



YOUTH & FAMILY  
SERVICES

Cycle Months \_\_\_\_\_ Year \_\_\_\_\_ 100% Juices: Cereals: Provider Name \_\_\_\_\_

Week 1 2 3 4

Provider Phone \_\_\_\_\_

Begin Dates: 

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Meal	Food Groups	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>BREAK-FAST</b> Time:	Fruit or Vegetable							
	Bread/Alternate							
	Fluid Milk Required	Milk	Milk	Milk	Milk	Milk	Milk	Milk
<b>LUNCH</b> Time:	Meat/Alternate							
	Bread/Alternate							
	Vegetable							
	Fruit							
	Fluid Milk Required	Milk	Milk	Milk	Milk	Milk	Milk	Milk
<b>SUPPER</b> Time:	Meat/Alternate							
	Bread/Alternate							
	Vegetable							
	Fruit							
	Fluid Milk Required	Milk	Milk	Milk	Milk	Milk	Milk	Milk
<b>SNACK</b> AM PM EV Time:	Meat/Alternate							
	Bread/Alternate							
	Fruit or Vegetable							
	Fluid Milk							
<b>SNACK</b> AM PM EV Time:	Meat/Alternate							
	Bread/Alternate							
	Fruit or Vegetable							
	Fluid Milk							

*When substituting, all meal components must be documented on the back of this form.*