EDINBURG C.I.S.D. CHILD NUTRITION DEPARTMENT
2016 ~ 2017 SPECIAL REQUEST FORM

Phone Number: (956) 289-2575 **Fax Number: (956) 380-8905**

Fill out one form per request. Return to the Child Nutrition Department office for approval ***10 working days*** prior to the date of the request. If this form is not received as stated, we will be unable to provide your request. Cancellations must be received *no later than* ***24 hours*** *in advance .*

CAMPUS: _____

☐ **SACK LUNCHES** **Date Needed:** _____ **Pick-up Time:** _____

Inform cafeteria manager if any students require menu modifications as per a doctors order.

Ice chests must be provided by facilitator for transportation of meals. Ice will be provided by CN Department.

Facilitator's Name: _____

Grade (s): _____

Room Number (s): _____

Number of Student Meals*: _____

Number of Paid Adult Meals:

***Menu will be planned by supervisor depending on age/grade group.**

***Lunches may not be picked up after 1:30 pm.**

☐ **MENU CHANGE** **Date(s):** _____

Menu changes can only be made within the same week. Contact your supervisor for approval.

Facilitator's Name: _____ Grade(s): _____

Room Number(s): _____

Breakfast ☐ Number of Breakfasts/Students: _____

Lunch ☐ Number of Lunches/Students: _____

Reason: _____

Requested Menu Change:

☐ **OFF-CAMPUS MEALS** **Date** _____

This section is filled out when sack lunches will NOT be ordered.

Please notify cafeteria manager when students will not be on campus so that he/she can plan accordingly.

Facilitator's Name: _____ Grade(s): _____

Room Number(s): _____

Breakfast ☐ Number of Breakfasts/Students: _____

Lunch ☐ Number of Lunches/Students: _____

Reason: _____

☐ **AFTER SCHOOL SNACKS** ☐ **DINNER** ☐ ***TESTING SNACKS**

check one

Only educational or enrichment activities are eligible for the After School Care Program. Snacks for testing are available for purchase. Contact your cafeteria manager for selections and prices.

A *P.O. number is required when purchasing snacks in order for request to be approved in a timely manner.

Facilitator's Name: _____ Grade(s): _____

Start Date: _____

End Date: _____ Days of Operation (circle days): **M TUE WED THUR FRI**

Number of Students: _____

Number of Paid Adult Snacks: _____ Room Number(s): _____

Reason/Activity: _____

P.O. # (for testing snacks only):

****After school snacks and/or dinner must be consumed on campus, meals cannot be taken home.***

☐ **SATURDAY SCHOOL** **Date:** _____ **Time:** _____

Sack breakfast and/or lunch can be delivered to the classrooms upon request. Contact your cafeteria manager.

Facilitator's Name: _____ Grade(s): _____

Room Number(s): _____

Breakfast _____ Number of Meals/Students: _____

Lunch _____ Number of Meals/Students: _____

_____ _____

Facilitator's Signature Date

_____ _____

Principal Signature Date

FOR CN OFFICE USE ONLY:

☐ **APPROVED**
☐ **DENIED**

_____ _____

Signature Date

Revised 01/2017