

**LEHIGH VALLEY CHILD CARE, INC.
EVENING SNACK**

MONTH/YEAR _____ PROVIDER'S NAME _____

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
EVE SNACK <u>LIST 2 ITEMS</u>	<input type="checkbox"/> ----- ----- -----	<input type="checkbox"/> ----- ----- -----	<input type="checkbox"/> ----- ----- -----	<input type="checkbox"/> ----- ----- -----	<input type="checkbox"/> ----- ----- -----
EVE SNACK <u>LIST 2 ITEMS</u>	<input type="checkbox"/> ----- ----- -----	<input type="checkbox"/> ----- ----- -----	<input type="checkbox"/> ----- ----- -----	<input type="checkbox"/> ----- ----- -----	<input type="checkbox"/> ----- ----- -----
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EVE SNACK <u>LIST 2 ITEMS</u>	<input type="checkbox"/> ----- ----- -----	<input type="checkbox"/> ----- ----- -----	<input type="checkbox"/> ----- ----- -----	<input type="checkbox"/> ----- ----- -----	<input type="checkbox"/> ----- ----- -----

LVCC REV 12/07

** **WHOLE MILK MUST BE SERVED TO ALL CHILDREN UNDER THE AGE OF 2 YEARS**

FOR CACFP OFFICIAL USE ONLY

TYPE OF MONITORING VISIT (CIRCLE ONE)

ANNOUNCED

UNANNOUNCED

DATE/TIME OF MONITORING VISIT _____

MEAL TYPE _____

DISALLOWANCE(S) ON DATE(S) _____

MONITOR'S INITIALS _____