AK Family Child Care Food Program 2221 E. Northern Lights, Suite 201 Anchorage, AK 99508 274-2237
Monthly Meal Count Sheet

DUE NO LATER THAN THE 5TH OF NEXT MONTH
DATE RECEIVED

Month: January Year: 2009 Provider: Your Name Here Provider Number: Your #

Child First & Last Name	DOB if ↓30 mo.	Related How?	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
Kimberly Smith	10/12/2008		B L A	B L A	B L A	B L A	B L A			B L A	B L A	B L A	B L A	B L A			B L A	B	B L A													
Joel Smith	/ /		B L A	B L A	B L A	B L A	B L A			B L A	B L A	B L A	B L A	B L A			B L A	B	B L A													
Zoe Anderson	/ /	GD						L A S	L A S						L A S	L A S																
Peter Anderson	/ /	GS						L A S	L A S						L A S	L A S																
Alexander Brown	/ /		B A	A	B A	B A	B A			B A	B A	B A	B A	B A			B A															
Tasha Brown	/ /		B A	A	B A	B A	B A			B A	B A	B A	B A	B A			B A															
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Daily Attendance			4	4	4	4	4	2	2	4	4	4	4	4	2	2	4	2	2													Totals
Breakfast (B)			4	2	4	4	4	2	2	4	4	4	4	4	2	2	4	2	2													
Morning Snack (M)																																
Lunch (L)			2	2	2	2	2	2	2	2	2	2	2	2	2	2	2		2													
Afternoon Snack (A)			4	4	4	4	4	2	2	4	4	4	4	4	2	2	4	2	2													
Supper (S)								2	2						2	2																
Evening Snack (S)																																

I certify that all the information submitted is true and correct. I understand that this information is being given in connection with the receipt of federal funds; that department officials may, for cause, verify information; and that deliberate misrepresentation may subject me to prosecution under applicable state and criminal statutes. The program must be made available to all eligible children regardless of age, sex, handicap, race, color, religion, or national origin.

PROVIDER'S SIGNATURE: _____ **DATE:** _____