

<b>Records Due On The 5th by 12:00 pm.</b> Mail To: Northwest Nutrition Service P.O. Box 68365 Milwaukie, Oregon 97268 <small>(503) 653-7626 or 1-800-600-6058</small>	Print Name: _____ Signature: _____ Phone #: _____	<b>Attendance</b>	<b>Tier</b>	<b>I</b>	<b>II</b>	
	Claim Month: _____ Year: _____ Account#: _____ Received: _____			<b>B</b>		
	"This institution is an equal opportunity provider"		<b>No. of Days</b>	<b>S</b>		
	I certify 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. This program must be made available to all eligible children regardless of age, sex, handicap, race, color, religion, or national origin.			<b>L</b>		
			<b>D</b>			

Circle Non- School Days	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						
<b>Breakfast-B</b>																																		Master Menu or Cycle Use Only  Indicate Master Menu or Cycle Used  S= substitute write substitu- tion on back			
<b>A.M. Snack-A</b>																																					
<b>Lunch-L</b>																																					
<b>PM Snack-P</b>																																					
<b>Dinner-D</b>																																					
<b>L.S. Snack-L/S</b>																																		<b>Tier</b>	<b>I</b>	<b>II</b>	
<b>First/Last Name</b>																																		<b>B</b>			
<b>Age:</b>																																		<b>S</b>			
<b>First/Last Name</b>																																		<b>L</b>			
<b>Age:</b>																																		<b>D</b>			
<b>First/Last Name</b>																																		<b>B</b>			
<b>Age:</b>																																		<b>S</b>			
<b>First/Last Name</b>																																		<b>L</b>			
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<b>First/Last Name</b>																																		<b>B</b>			
<b>Age:</b>																																		<b>S</b>			
<b>First/Last Name</b>																																		<b>L</b>			
<b>Age:</b>																																		<b>D</b>			

OFFICE USE ONLY DO NOT WRITE BELOW		
Start Date: _____ Record Check: _____ Home Visit: _____ Daily <input type="checkbox"/> Own Cycle <input type="checkbox"/> Cycle <input type="checkbox"/> Master <input type="checkbox"/> Exception: 1 2 3 4 5 6 7 8 Group Home <input type="checkbox"/> DHS Exempt Care <input type="checkbox"/> Income Eligibility: Yes No Own NP: _____ Review <input type="checkbox"/> Red Flag <input type="checkbox"/> Non-Compliance <input type="checkbox"/> Serious Deficiency <input type="checkbox"/>	Expired Reg: _____  Pending Reg: _____  Add Chg: _____	Office Memo: _____ _____ _____ _____