



DAY CARE HOME MENU

**Provider's Name:** \_\_\_\_\_ Please send original to Sponsor. Retain a copy for your records. **Month** \_\_\_\_\_ **Year** \_\_\_\_\_

CACFP REQUIREMENTS		Date: Monday	Date: Tuesday	Date: Wednesday	Date: Thursday	Date: Friday
<b>BREAKFAST</b>	Fluid Milk (specify type of milk)					
	Fruit or Vegetable					
	Bread* or Bread Alternate*					
	Other					
<b>AM SNACK</b> Serve 2 of 4 groups	Fluid Milk (specify type of milk)					
	Fruit or Vegetable					
	Bread* or Bread Alternate*					
	Meat or Meat Alternate					
	Water					
<b>LUNCH</b>	Fluid Milk (specify type of milk)					
	Meat or Meat Alternate					
	2 Servings of Fruit and/or Vegetables					
	Bread or Bread Alternate					
	Other					
<b>PM SNACK</b> Serve 2 of 4 groups	Fluid Milk (specify type of milk)					
	Fruit or Vegetable					
	Bread* or Bread Alternate*					
	Meat or Meat Alternate					
	Water					
<b>SUPPER</b>	Fluid Milk (specify type of milk)					
	Meat and Meat Alternate					
	2 Servings of Fruit and/or Vegetables					
	Bread or Bread Alternate					
	Other					
<b>LN SNACK</b> Serve 2 of 4 groups	Fluid Milk (specify type of milk)					
	Fruit or Vegetable					
	Bread* or Bread Alternate*					
	Meat or Meat Alternate					
	Water					

\*No more than 2 servings of sweet grains or sweet cereals may be served per week.



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