CACFP
Child and Adult Care Food Program
New York State Department of Health

ATTENDANCE AND MEAL COUNT

Provider Name & Address: _____ **MONTH:** _____

Enter the full names of children	Day: / Date	Su	M	T	W	T	F	Sa	Su	M	T	W	T	F	Sa	Su	M	T	W	T	F	Sa	Su	M	T	W	T	F	Sa	Su	M	T	W	T	F	Sa	Su	M	T	**TOTALS FOR MONTH**
Name:	P																																						**P:**
	B																																						B:
	S																																						AMS:
	L																																						L:
	S																																						PMS:
Age:	D																																						D:
	S																																						ES:
Name:	P																																						**P:**
	B																																						B:
	S																																						AMS:
	L																																						L:
	S																																						PMS:
Age:	D																																						D:
	S																																						ES:
Name:	P																																						**P:**
	B																																						B:
	S																																						AMS:
	L																																						L:
	S																																						PMS:
Age:	D																																						D:
	S																																						ES: