MEAL COUNT FORM

Agency Name: _____

Agency #: _____ **For The Week Of**: _____

Plate Count/Head Count By Day							
	Breakfast	**Snacks**	**Lunch**	**Snacks**	**Dinner**	**Snacks**	**Other**
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							
Total							

Plate Count/Head Count Total For The Week: _____

This institution is an equal opportunity provider.