Meal Count Summary Sheet

Name of Center: _____ Claiming Month/Year: _____

Date	Number of Meals Claimed for Enrolled Participants						Number of Meals Claimed for Infants (if applicable)						At-Risk (if applicable)	
	Breakfast	AM Snack	Lunch	PM Snack	Supper	Night Snack	Breakfast	AM Snack	Lunch	PM Snack	Supper	Night Snack	At-Risk Snack	At-Risk Supper
1														
2														
3														
4														
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25														
26														
27														
28														
29														
30														
31														
Subtotal							----	----	----	----	----	----		
A. Infant Totals*														
Total # Meals to Claim							Breakfast	AM Snack	Lunch	PM Snack	Supper	Night Snack	At-Risk Snack	At-Risk Supper
	Breakfast	AM Snack	Lunch	PM Snack	Supper	Night Snack	* TRANSFER TOTALS TO ROW A. INFANT TOTALS *							