EDINBURG C.I.S.D. CHILD NUTRITION DEPARTMENT
2022 ~ 2023 SPECIAL REQUEST FORM

Phone Number: (956) 289-2575 **Fax Number: (956) 380-8905**

Fill out one form per request. Return to the Child Nutrition Department office for approval ***10 working days*** prior to the date of the request. If this form is not received as stated, we will be unable to provide your request. Cancellations must be received *no later than* ***24 hours*** *in advance*.

CAMPUS: ______

☐ **SACK LUNCHES** **Date Needed:** ______ **Pick-up Time:** ______

Inform cafeteria manager if any students require menu modifications as per a doctors order.
Ice chests must be provided by facilitator for transportation of meals. Ice will be provided by CN Department.

Facilitator's Name: ______
Grade (s): ______
Room Number (s): ______
Number of Student Meals*: ______
Number of Paid Adult Meals:

Menu will be planned by supervisor depending on age/grade group.

Lunches may not be picked up after 1:30 pm.

☐ **MENU CHANGE** **Date(s):** ______

Menu changes can only be made within the same week. Contact your supervisor for approval.

Facilitator's Name: ______ Grade(s): ______
Room Number(s): ______
Breakfast ☐ Number of Breakfasts/Students: ______
Lunch ☐ Number of Lunches/Students: ______
Reason: ______
Requested Menu Change:

☐ **OFF-CAMPUS MEALS** **Date** ______

This section is filled out when sack lunches will <u>NOT</u> be ordered.
Please notify cafeteria manager when students will not be on campus so that he/she can plan accordingly.

Facilitator's Name: ______ Grade(s): ______
Room Number(s): ______
Breakfast ☐ Number of Breakfasts/Students: ______
Lunch ☐ Number of Lunches/Students: ______
Reason: ______

☐ **AFTER SCHOOL SNACKS** ☐ **DINNER** ☐ ***TESTING SNACKS**

check one

Only educational or enrichment activities are eligible for the After School Care Program. Snacks for testing are available for purchase. Contact your cafeteria manager for selections and prices.
A *P.O. number is required when purchasing snacks in order for request to be approved in a timely manner.

Facilitator's Name: ______ Grade(s): ______
Start Date: ______
End Date: ______ Days of Operation (circle days): **M TUE WED THUR FRI**
Number of Students: ______
Number of Paid Adult Snacks: ______ Room Number(s): ______
Reason/Activity: ______

P.O. # (for testing snacks only):
*****After school snacks and/or dinner must be consumed on campus, meals cannot be taken home.***

☐ **SATURDAY SCHOOL** **Date:** ______ **Time:** ______

Facilitator's Name: ______ Grade(s): ______
Room Number(s): ______
Breakfast ______ Number of Meals/Students: ______
Lunch ______ Number of Meals/Students: ______

***Breakfast will be a light snack and Lunch will be a full lunch.**

______ Facilitator's Signature ______ Date

______ Principal Signature ______ Date

FOR CN OFFICE USE ONLY:

☐ **APPROVED**
☐ **DENIED**

______ Signature ______ Date

Revised 08/2019