Provider Name: _____ Cycle Months:_____ 100% Juices: Cereals:

Week 1 2 3 4

Begin Dates: | | | | | |

Meal	Food Groups	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
BREAKFAST	Fruit or Vegetable							
	Bread/Alternate							
	Meat Optional							
	Fluid Milk Required	Milk	Milk	Milk	Milk	Milk	Milk	Milk
LUNCH	Meat/Alternate							
	Bread/Alternate							
	Vegetable							
	Fruit/Vegetable							
	Fluid Milk Required	Milk	Milk	Milk	Milk	Milk	Milk	Milk
SUPPER	Meat/Alternate							
	Bread/Alternate							
	Vegetable							
	Fruit/Vegetable							
	Fluid Milk Required	Milk	Milk	Milk	Milk	Milk	Milk	Milk
SNACK AM PM EV	Meat/Alternate							
	Bread/Alternate							
	Fruit							
	Vegetable							
	Fluid Milk							
SNACK AM PM EV	Meat/Alternate							
	Bread/Alternate							
	Fruit							
	Vegetable							
	Fluid Milk							

When substituting, all meal components must be documented on the back of this form. *Youth & Family Services is an equal opportunity provider.*

Children 1 year whole milk. Children 2 years & older 1% or skim milk

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