Child Nutrition Program of Southern California

SHIFT FORM

Provider No. ____________________

Month ____________________

MEAL TIMES

	B	S	L	S	D
SHIFT 1					
SHIFT 2					

CHILD'S NAME	#	6	15	30	45	7	15	30	45	8	15	30	45	9	15	30	45	10	15	30	45	11	15	30	45	12	15	30	45	1	15	30	45	2	15	30	45	3	15	30	45	4	15	30	45	5	15	30	45	6	15	30	45	7	15	30	45	8	15	30	45	9	PARENT'S INITIALS**
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I certify that the information on my child care shift form is true and correct

Provider Signature ____

** We must have Parent's Initials above for verification of hours.

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