IRVING INDEPENDENT SCHOOL DISTRICT
Food Service Department

Request for the IISD After School Snack Program

SCHOOL NAME: _____ DATE: _____

PROGRAM NAME: _____

NUMBER OF STUDENTS IN PROGRAM: _____

PROGRAM MEETING DAYS: M T W TH F (circle all that apply)

START DATE/END DATE: _____ TIME: _____

CONTACT PERSON: _____ PHONE NUMBER: _____

PRINCIPAL'S SIGNATURE: _____

Description of After-School Program:

(NOTE: Request for snacks must be made **two (2) weeks** in advance of the program start date)

For Food Service office use only
Date Received: _____ *Approved* ____ *Denied* ____