



**La Joya Independent School District  
Child Nutrition Services  
After School Snack Program Request**

Request **must be submitted 5 days prior to date of service** to be honored.

Campus: \_\_\_\_\_ Date: \_\_\_\_\_

Principal: \_\_\_\_\_

Program Name: \_\_\_\_\_

**Start Date:** \_\_\_\_\_ **End Date:** \_\_\_\_\_

Provide Service Dates Monthly: *(Example: Jan, 1, 2, 3 Feb, 5, 6, 7)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Time: \_\_\_\_\_ # of Participants \_\_\_\_\_

Days of Service: \_\_\_\_\_  
(i.e. Mon-Thru, Mon & Wed only, etc.)

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Description of After-School Program:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For Child Nutrition Services Use Only:**

APPROVED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

Revised 08/2017

