Fabens Independent School District
Child Nutrition Services
Catering Request

Date of Request: _____

Vendor name: **Fabens ISD Food Service Catering**
Vendor ID: **4**

Campus/location: _____ Dept.: _____

Date of Service: _____ Time: _____

Contact Person: _____ Phone: _____

Number to be Served: _____

MENU: (MUST HAVE 2 WEEKS IN ADVANCE NOTICE)

_____

_____

_____

_____

_____

_____

Estimated Cost Per Person $: _____ **Total Cost $:** _____

* Final cost includes the total cost of labor and supplies.

SPECIAL INSTRUCTIONS:

_____

_____

_____

_____

Administrator/Principals signature: _____ Date: _____

FORWARD TO:

Forward all copies to the Child Nutrition Food Services Department. A signed copy with the cost estimate will be forwarded back to the originator.

APPROVAL

Campus Cafeteria Manager: _____ Date: _____

Child Nutrition Director: _____ Date: _____