Sharyland ISD
CNP Department

School Name: _____
Principal: _____
Date: _____

CACFP At risk -Afterschool Meal Program Request

2026-2027

***NOTE: All lines must be completed w/the required information. An incomplete request will delay processing. If meal service needs to be cancelled, please notify the cafeteria manager by 10:00 AM on the day of service to help prevent waste and ensure efficient operations. Thank you for your cooperation.**

Name of Principal or Designee: _____

Educational/Enrichment Activity: _____

Starting date: _____ Ending date: _____

Days of service: _____ Time of Service: _____
(i.e.., Monday - Friday)

Description of Educational/Enrichment Activity: _____

_____

_____

_____

_____

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_____

CNP Office Only:

Date Received: _____

Approved by: _____

Approved Date: _____