

**City of St. Charles School District**

**Birthday Treat Form**



Date of Event: \_\_\_\_\_\_\_\_\_\_\_\_\_ School: HARRIS

Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Customer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Treat selected: | One per Class |
| o $.75 Each | Fresh Apple or Banana |
| o $.75 Each | Crazy Color Fruit Roll Up |
| o $.95 Each | Chocolate/Vanilla Ice Cream Cup/Slushies’ |
| o $.95 Each | Double Chocolate Chip Muffin |

We would appreciate a week advance notice for the birthday treats. Payment must be received prior to receiving the birthday treats. Sorry, no charging allowed.

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Completed by the Manager

No. of Students in the Class \_\_\_\_\_\_\_\_\_ x \_\_\_\_\_\_\_\_\_\_\_= Amount Owed: $\_\_\_\_\_\_\_\_\_

Amount Paid on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Allergies in the classroom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (completed by Manager)

The Food Service Department at The City of St. Charles School District is committed to providing the highest quality service possible.