

**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.