

**B.**

# ATTENDANCE REPORT



CACFP  
P.O. BOX 495  
DOVER, DE 19903  
674-1600

Provider's Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_

Month and Year \_\_\_\_\_

NAME OF CHILD	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	TOTAL
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2.																																
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**TOTAL**

**CERTIFICATION**

I certify that the information submitted is accurate in all respects, and that I understand this information is given in connection with the receipt of Federal Funds, and that deliberate misrepresentation may result in State or Federal prosecution.

**P = Present**

**A = Absent**

Signature \_\_\_\_\_ Date \_\_\_\_\_