Oregon Department of Education
255 Capitol Street NE
Salem, OR 97310

Office of Student Services
Child Nutrition Programs

ODE CNP PROVIDER MONITORING REVIEW FOR

Date _____ S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ SA ☐ Arrival Time _____ Departure Time _____

Review Type: 30 day ☐ 1st ☐ 2nd ☐ 3rd ☐ Other _____ Review: U ☐ A ☐

Provider Name _____ Phone _____ OCC License # _____

OCC Capacity ____ DHS Provider Y ☐ N ☐ Date of Provider's last training _____

OCC Expiration Date _____ OCC License/business hours: Beginning time _____ Ending time _____

Finding(s) from previous reviews, if applicable: _____

_____

Finding(s) corrected? **Y** ☐ **N** ☐ **Comments** _____

Names of Children Enrolled and in Care

Name	Age		Enrollment Form (Y/N)	Name	Age	Enrollment Form (Y/N)

Meal/Snack Observed ☐ **Y** ☐ **N**	**B** ☐ **AM** ☐ **L** ☐ **PM** ☐ **SU** ☐ **EVE** ☐	
Component	**Actual Food Served**	**Portion size**
Milk		
Meat/Meat Alternate		
Vegetable		
Fruit-Vegetable		
Grain/Bread		

During the Provider review, were any imminent health or safety issues observed and reported? If yes, describe situation and actions taken in comments section below.	**Y** ☐ **N** ☐
Is provider over licensed capacity?	**Y** ☐ **N** ☐
Are meals/snacks claimed over licensed capacity?	**Y** ☐ **N** ☐
Attendance (time in/out) current to the time of the review?	**Y** ☐ **N** ☐
Meal counts current to the time of the review?	**Y** ☐ **N** ☐
Menu accurately documents components per CACFP Requirements?	**Y** ☐ **N** ☐
Provider in compliance with infant feeding & infant documentation requirements?	**Y** ☐ **N** ☐
Does the Provider have CN labels, Ingredient labels, Nutrition Facts Labels, etc. available as required?	**Y** ☐ **N** ☐
Are substitutions accurately recorded?	**Y** ☐ **N** ☐
Are medical statements for substitutions on file when required? Not applicable ☐	**Y** ☐ **N** ☐
Meal service style: Restaurant ☐ Family Style ☐ Were portion sizes met for the meal service style and for the age of the child?	**Y** ☐ **N** ☐
Meals are prepared and served within health & safety standards (food preparation areas; utensils; eating area)	**Y** ☐ **N** ☐
The provider encourages children to wash hands prior to eating? No meal observed, not applicable ☐	**Y** ☐ **N** ☐
Are provider's own children claimed? **Y** ☐ **N** ☐ If yes, is an income eligibility form on file?	**Y** ☐ **N** ☐
Are current and complete Child Enrollment Forms on file for each child in care?	**Y** ☐ **N** ☐
Are all USDA records for the last 12 months and current month maintained in the provider's home? Where are previous 3 years documents stored _____	**Y** ☐ **N** ☐

5-Day Reconciliation:Dates reviewed:_____to_____Meal types reviewed **B**☐ **AM**☐ **L**☐ **PM**☐ **SU**☐ **E**☐

Attendance & enrollment records support meal counts **Y** ☐ **N** ☐ **If No, explain and document disallows:**

_____

Are fewer children present than normally claimed? **Y** ☐ **N** ☐ **If Yes, explain**

_____

Meals disallowed and reasons: _____

_____

Technical Assistance/Training offered: _____

Findings of non-compliance identified in this review _____

Serious Deficiency? **Y** ☐ **N** ☐

Corrective Action: _____

Reviewer's signature _____ Date: _____

Provider's signature: _____ Date: _____

Comments: _____

 This Institution is an equal opportunity provider.