Etiwanda School District–Child Nutrition Dept.
12999 Victoria St. Etiwanda, CA. 91739

CATERING REQUEST/INVOICE 2017/2018

Please submit request 3 weeks prior to event

Questions? Call: (909)803-3165 or 803-3164
Billing questions call: (909)803-3155

VISIT US AT www.ESDChildNutrition.com FOR MORE INFORMATION AND TO ACCESS OUR ONLINE CATERING FORM AND BROCHURE

Date of Event:		**Time of Event:**	
Site & Location of Event:		**Purpose of Event:**	
Person Requesting:		**Authorized Signature:**	
◯ **Please send me an invoice for billing**		◯ **Please bill the following budget code:**	

MENU ITEM	TYPE (Please specify)	QTY (gal., doz., cup, ea…)	PER PERSON COUNT	TOTAL COST (CN Office Only)
Coffee				
Hot Cocoa				
Juice (Apple or Orange)				
Lemonade/Punch				
Milk				
Soda				
Tea (Hot or Iced)				
Water				

Date received by Child Nutrition: _____

SPECIAL INSTRUCTIONS: (list color scheme or theme if choosing service ware other than white….*additional charges incurred)

FOOD SERVICE COST BREAKDOWN	
	AMOUNT
FOOD:	
SUPPLIES*:	
LABOR:	
HANDLING:	
DELIVERY:	
SUBTOTAL:	
TAX*:	

Etiwanda Child Nutrition

EVENT TOTAL $

CHILD NUTRITION BILLING INFORMATION			
Invoice Date:		Interfund Transfer Date:	
2nd Notice:			
Cash:		Cash/Check Deposit Date:	
Check #:			
Received By:		Deposited By:	

INVOICE #: