**Birthday Ice Cream Order Form**

Parent will complete information below and submit with payment to the school office at least **two weeks prior to the event**.

School office staff will complete their section and submit to school nurse to enter dietary restrictions.

A copy of the form will be submitted to the teacher and the original form with payment submitted to the school nutrition manager by the office staff. **The cost is fifty cents (50 cents)** **per treat.**

**Below to be completed by parent/guardian**

Student Name:

Teacher/Home Room:

Day/Date of Event: # of treats needed:

Ice Cream Choice: \_\_\_ Fudge Bar (Gluten-Free) \_\_\_ Ice Cream Sandwich

 \_\_\_\_ Orange Push-Up (Gluten-Free) \_\_\_ Cotton Candy

**TREAT CHOICE MAY BE SUBSTITUTED BASED ON AVAILABILITY AT TIME THE ORDER RECEIVED.**

A dairy-free treat (such as a fruit slush) will be provided for those with dairy intolerance/allergies as indicated by nurse below.

**Below to be completed by school personnel**

Amount Paid: \_\_\_\_ Cash \_\_\_\_ Check #\_\_\_\_

For any change due (select one): \_\_\_\_ Deposit in my child’s lunch account

 \_\_\_\_ Return to parent in child’s folder/backpack

\_\_\_\_\_ **Treats to be available for teacher pick-up by 2:00 p.m. on date of event.**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

 **Below this line to be completed by school personnel**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

Students with known dietary restrictions (indicated on student health form)

\_\_\_\_\_ No known dietary restrictions requiring alternate treat for this classroom.

\_\_\_\_\_ See below for known dietary restrictions requiring an alternate treat.

 Student Name Dietary Restriction/Alternate Treat Needed

\_\_\_\_\_ (initial) Nurse Reviewed

\_\_\_\_\_ (initial) Copy to teacher

**\_\_\_\_\_ (**initial) Submitted to school nutrition manager with payment on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

**Hoja de Pedido de Helado/Nieve para la Celebración de Cumpleaños**

Los padres deben llenar esta hoja y devolver a la oficina escolar con el pago **dos semanas antes del evento**.

El personal escolar llenará su sección y lo entregará a la enfermera escolar quien incluirá cualquier restricción dietética.

Se entregará una copia de la hoja al maestro y el personal de la oficina entregará la hoja original con el pago al gerente de nutrición escolar. **El costo es cincuenta centavos ($0.50) cada uno.**

**Padre/Tutor: Favor de completar la información solicitada abajo**

Nombre del Estudiante:

Maestro/Salón Principal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Día/Fecha del Evento: # de helados/alternativa que necesita:

Selección de Helado: \_\_\_\_ Paleta de Helado de Chocolate (Sin Gluten) \_\_\_ Sándwich de Helado

 \_\_\_\_ Naranja Push Up (Sin Gluten) \_\_\_ Algodón de Azúcar

**SE PUEDE SUSTITUIR LA SELECCIÓN DEPENDIENDO DE SU DISPONIBILIDAD AL MOMENTO DE RECIBIR EL PEDIDO.**

Proporcionaremos una alternativa libre de lácteo (como aguanieve de fruta) para aquellos con intolerancia / alergia al lácteo según la enfermera lo indique abajo.

Si sobra cambio (seleccione uno): \_\_\_\_ Deposite el cambio en la cuenta de almuerzo de mi niño(a).

 \_\_\_\_ Devuelva el cambio en el folder/mochila de mi niño(a).

**Esta sección será completada por el personal escolar**

Amount Paid: \_\_\_\_ Cash \_\_\_\_ Check #\_\_\_\_

\_\_\_\_\_ **Treats to be available for teacher pick-up by 2:00 p.m. on date of event.**

 **Below to be completed by school nurse**

Students with known dietary restrictions (indicated on student health form)

\_\_\_\_\_ No known dietary restrictions requiring alternate treat for this classroom.

\_\_\_\_\_ See below for known dietary restrictions requiring an alternate treat.

 Student Name Dietary Restriction/Alternate Treat Needed

\_\_\_\_\_ (initial) Nurse Reviewed \_\_\_\_\_ (initial) Copy to teacher

**\_\_\_\_\_ (**initial) Submitted to school nutrition manager with payment on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)