**HOME VISIT REVIEW REPORT**

**Provider Name:** ____________________________  
**Date:** ____________________________  
**Phone Number:** ____________________________  

**Address:** ____________________________  
**Arrival Time:** ____________  
**Departure Time:** ____________  

**License Information:**  
- **Number:** ____________  
- **Effective:** ____________  
- **Expiration:** ____________  
- **Capacity:** ____________  
- **Posted:**  
  - Yes  
  - No  

**KDHE Exception:**  
- Yes  
- No  

**Type of Visit:** (Check all that apply)  
- Announced  
- Unannounced  
- Meal/Snack  
- Admin  
- Follow-up  
- 5-Day Reconciliation:  
  - Onsite  
  - Office  

**Meal Times:**  
- Breakfast ____________________________  
- Lunch ____________________________  
- Dinner ____________________________  

(Circle meal observed)  
- AM Snack ____________________________  
- PM Snack ____________________________  
- Eve Snack ____________________________  

**Days of Operation:**  
- Mon  
- Tues  
- Wed  
- Thurs  
- Fri  
- Sat  
- Sun  

**Care provided on major holidays?**  
- Yes  
- No  

**Full Name of Children in Attendance**  
<table>
<thead>
<tr>
<th>Age</th>
<th>Meal Participant?</th>
<th>Provider’s Child?</th>
<th>Menu Items Served</th>
<th>Infant Menu Items Served</th>
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**Meal Service**  
- Yes  
- No  
- N/A  

**Comments:**  

**Food Safety and Sanitation**  
- Yes  
- No  
- N/A  

**Comments:**  

**Menu Evaluation**  
- Yes  
- No  
- N/A  

**Comments:**  

**Record Keeping and Capacities**  
- Yes  
- No  
- N/A  

**Comments:**  

**Reviewer’s Signature** ____________________________  
**Date:** ____________________________  

**Provider’s Signature** ____________________________  
**Date:** ____________________________  

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This institution is an equal opportunity provider.

07/2021  
Child Nutrition & Wellness, Kansas State Department of Education