Clarinda Regional Health Center

FRESH EATS MEAL CONTRACT

REV 12/19

Name:_____

Address:_____

Phone Number:_____

Diet:_____

Milk Preference (Skim, 2%, Choc):_____

Allergies:_____

Bread Preference (White or Wheat):_____

Delivery Instructions: _____

Emergency Contact Name:_____

Emergency Contact Phone Number: _____

Signature:_____ **Date:**_____

Each Meal will cost $7.00 per meal. A bill will be sent out monthly to you. Please make payments to Clarinda Regional Health Center on a timely basis. Please turn in this form with the driver who delivers your meal.

If you need to cancel your meal, please call the Dietary Department by 9:30 AM. If you have any questions or concerns, please contact our Dietary Department at 712-542-8215.

Thank you for choosing Fresh Eats!