

MENU

(Preplan menu before grocery shopping for home)

Name of home or address _____

Month/Year _____

| Meals | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|--------------------------|--------|---------|-----------|----------|--------|----------|--------|
| BREAKFAST | | | | | | | |
| Protein | | | | | | | |
| Grain | | | | | | | |
| Vegetable | | | | | | | |
| Fruit | | | | | | | |
| Dairy | | | | | | | |
| Beverage | | | | | | | |
| Snack (if applicable) | | | | | | | |
| LUNCH | | | | | | | |
| Protein | | | | | | | |
| Grain | | | | | | | |
| Vegetable | | | | | | | |
| Fruit | | | | | | | |
| Dairy | | | | | | | |
| Beverage | | | | | | | |
| Snack (if applicable) | | | | | | | |
| DINNER | | | | | | | |
| Protein | | | | | | | |
| Grain | | | | | | | |
| Vegetable | | | | | | | |
| Fruit | | | | | | | |
| Dairy | | | | | | | |
| Beverage | | | | | | | |
| Snack (if applicable) | | | | | | | |

Not all individuals will have three snacks a day, especially if watching weight. Snacks spaces are for snacks recommended by nurse, doctor or RD.

Last updated 4-9-10 SO