

# Monthly Lunch/Milk Order Form

Student Name: \_\_\_\_\_

Room: \_\_\_\_\_

Grade: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

**If writing a check, please make payable to: DOC Nutrition Services**

# of Days Lunch Desired (Milk included with lunch) →	
Multiplied by Lunch Cost Paid \$3.00, Reduced 40¢ or Free	
Total Lunch Cost	
# of Days Milk Only Desired	
Multiplied by Milk Cost 50¢	
Total Milk Cost	
Grand Total (Lunch plus Milk)	

**Please place only one symbol per day:**

**L = Lunch**

**M = Milk only (milk is included with the lunch)**

## December 2020

Monday	Tuesday	Wednesday	Thursday	Friday
Week 4-Orange	1	2	3	4
Week 1-Blue	7	8	9	10
Week 2-Green	14	15	16	17
Week 3-Yellow	21	22	23	24
Week 4-Orange	28	29	30	31

CHRISTMAS

NEW YEAR'S EVE

This institution is an equal opportunity provider