

# 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 \$3.25, Reduced 0.00¢ 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)**

## January 2025

Monday	Tuesday	Wednesday	Thursday	Friday
		1 <b>NEW YEAR'S DAY</b>	2 Green	3
4 Yellow	5 7	6 8	7 9	8 10
9 Orange	10 14	11 15	12 16	13 17
14 <b>MARTIN LUTHER KING DAY</b>	15 Blue	16 21	17 22	18 23
19 Green	20 28	21 29	22 30	23 31

This institution is an equal opportunity provider