NORTHWEST NUTRITION SERVICE DAILY MEALCOUNT FORM

Print Name: ______________________ Signature: _____________________ Acct.#: ______________ Phone: _______________ Claim Month: ______________ Year: ____________

Records due by the 5th: Mail to P.O. Box 68365 Milwaukie, Oregon 97268 (503) 653-7626 or Fax (503) 653-1484 or email: information@nwnutritionservice.com.

I certify the information submitted is accurate in all respects. I understand that this information is given in connection with the receipt of federal funds and that deliberate misrepresentation may result in State or Federal prosecution.

"X" Non-School Days			2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Office Use Only
First/Last Name	B																																B
	L																																L
	D																																D
Milk Served_____	AM																																AM
Age:	PM																																PM
Relative: ☐	LS																																LS
First/Last Name	B																																B
	L																																L
	D																																D
Milk Served_____	AM																																AM
Age:	PM																																PM
Relative: ☐	LS																																LS
First/Last Name	B																																B
	L																																L
	D																																D
Milk Served_____	AM																																AM
Age:	PM																																PM
Relative: ☐	LS																																LS
First/Last Name	B																																B
	L																																L
	D																																D
Milk Served_____	AM																																AM
Age:	PM																																PM
Relative ☐	LS																																LS
First/Last Name	B																																B
	L																																L
	D																																D
Milk Served_____	AM																																AM
Age:	PM																																PM
Relative ☐	LS																																LS

Monitor______________________
Review Date_________________

This institution is an equal opportunity provider

WM= Whole Milk
FF= Fat Free
1%=1% Milk