

Student Meal Account Refund Request

Student's Name: _____

Student's Campus: _____

Parent / Guardian's Name: _____

*Email Address: _____

*Phone Number: _____

*Mailing Address:

Balance to be refunded: _____

Balance to be transferred: _____ Transfer to: _____

When form is completed, please turn in to Cafeteria or forward to the Child Nutrition Dept. Cash refunds less than \$10.00 may be refunded from the register. All requests over \$10.00 are sent to finance to be processed in the form of a check. Refund checks are mailed within two weeks of receipt in the CNS office.

*Required information

Cashier: Initial to indicate requested amount has been deducted from student's account _____
Please attach a printout.