

## SCHOOL NUTRITION PARENT REFUND REQUEST

For refund check parent/guardian must complete information below and return to cafeteria manager or School Nutrition Services. Mailing address - 407 N. Main St. Suite 100, Monroe, NC 28112 or fax # 704-292-2639.

The cafeteria manager needs to attach a copy of student history showing balance before sending to Central Services. Checks will be mailed out in 2-3 weeks.

Refunds on accounts may only be requested by the legal guardian of the student and in the case of joint guardianship both guardians must consent to the refund.

DATE \_\_\_\_\_ PHONE \_\_\_\_\_

PARENT NAME \_\_\_\_\_

PARENT NAME \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_

STUDENT NAME \_\_\_\_\_ STUDENT # \_\_\_\_\_

STUDENT NAME \_\_\_\_\_ STUDENT # \_\_\_\_\_

STUDENT NAME \_\_\_\_\_ STUDENT # \_\_\_\_\_

STUDENT NAME \_\_\_\_\_ STUDENT # \_\_\_\_\_

AMOUNT OF REFUND \_\_\_\_\_

REASON FOR REFUND \_\_\_\_\_

MANAGER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

|   |   |
|---|---|
| Approval to Pay<br><br>_____<br>SNS Director/SNS Supervisor | This instrument has been pre audited in the manner required by the School Budget and Fiscal Control Act.<br><br>_____<br>Finance Officer/Designee      Date |
| Acc. # 5.2410.000.000                                       | Ck # _____ Date _____ Amt. _____  |