Child Nutrition Services

Rowan-Salisbury
SCHOOL SYSTEM
Extraordinary Education Every Day

Request for Refund of Account Balance

School: ______________________ **Request Date:** ______________

Name on Account: ______________________

Student ID #: ______________________

Amount of Refund: ______________________

I am requesting a refund from the account listed above. I realize that a check will be mailed from the Child Nutrition Services Office and that it may take two (2) to three (3) weeks for the check to be processed and mailed.

Signature: ______________________

Relationship to Account Holder: ______________________

Please provide the name and address to which a refund check is to be mailed:

____

Please Print **Name**

____

Address

____

City , State, Zip

____

Phone # where you may be reached in case clarification needs to be made.

*Please return this form to the cafeteria manager at your child's school <u>or</u> mail to:

Rowan-Salisbury Schools
Attn: Child Nutrition
PO Box 2349
Salisbury, NC 28145-2349