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: _____

or

Balance to be transferred (sibling only): _____

Sibling Name: _____

Parent Signature:_____ Date:_____

When form is completed, please email it back to carolina.arizpe@leanderisd.org AND kim.frank@leanderisd.org. All requests are sent to finance to be processed in the form of a check. Refund checks are mailed within two weeks of receipt to the CNS office, however due to COVID-19, please allow for additional processing time.

***For internal use only* CNS Department**: Initial to indicate requested amount has been deducted from student's account_____
Please attach a printout.