SAGINAW TOWNSHIP COMMUNITY SCHOOLS
NUTRITION SERVICES DEPARTMENT

PO Box 6278
Saginaw, MI 48608

ACCOUNT BALANCE REFUND/TRANSFER REQUEST

This form requires parental approval (signature preferred).
Please use ink when filling out the form.

Please use one form per family.

Student Name: _____ **School:** _____

Student Name: _____ **School:** _____

Student Name: _____ **School:** _____

Student Name: _____ **School:** _____

Parent Name: _____ **Phone:** _____

Parent Signature: _____ **Date:** _____

Make check payable to: _____ **Relationship to student:** _____

Mail check to:

Address: _____

City: _____ **State:** _____ **Zip:** _____

Reason for refund:

- ☐ **Deposited into lunch account in error**
- ☐ **Leaving school district**
- ☐ **Student now receives free meals**
- ☐ **Graduating senior**
- ☐ **Transfer to sibling account**
- ☐ **Donate balance to "Pay It Forward" Fund**
- ☐ **Other**_____

For office use only

Account Number: **25L4710008**

Account Cleared **Amount** _____ **Date:** _____ **Account cleared by:** _____