SAGINAW TOWNSHIP COMMUNITY SCHOOLS
NUTRITION SERVICES DEPARTMENT

PO Box 6278
Saginaw, MI 48608

ACCOUNT BALANCE REFUND REQUEST

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

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**

☐ **Other** _____

For office use only

Account Number: **25L4710008**

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

Use one form per family please.