

Meal Account Refund/Transfer Request

Purpose of submitting this form:

Requesting a refund

Requesting funds be transferred to a sibling

Student's School: _____

Student's Name: _____ Student's ID Number: _____

Transfer to Sibling – Sibling's Name: _____ Sibling's ID Number: _____

Sibling's School: _____

Parent's Name: _____ Phone: _____

Mailing Address _____

City, State Zip _____

Refund/Transfer Amount: _____

Reason for Refund/Transfer: _____

Please note that student's meal account money is automatically carried over to the next school year EXCEPT after completion of the 8th grade. If your child will not be attending a school within the Fullerton School District, please notify our office.

No refund is required for maintaining the balance.

Date: _____

Signature of Parent/Guardian

Date: _____

Signature of Cafeteria Worker

District Staff Only: ATTACH A COPY OF PARTICIPATION REPORT FOR THE STUDENT.

Parents: Fill out this form completely. Sign it. Mail it to:

**Nutrition Services
Fullerton School District
389 W. Truslow Ave.
Fullerton, CA 92832**