MEAL ACCOUNT REFUND/TRANSFER REQUEST

Student's name: _____ **Date**: _____

ID#: _____ **Amount of Refund** $_____
(if known)

Reason for Refund: ____ Student graduated _____ Student leaving district

Parent Signature: _____

Mail check to (address): _____

_____

Phone number: _____

Please indicate whether you are requesting a refund or would like to transfer funds to another student's meal account within the district.

_____ Refund full balance in account

_____ Transfer $_____ to Student Name:_____ ID# _____

_____ Donate the remainder of my child's meal account balance to a student in need

Please return this form to:
William Floyd UFSD
Food Services
240 Mastic Beach Road
Mastic Beach, NY 11951
Fax: 631-874-1847
Email: foodservices@wfsd.k12.ny.us