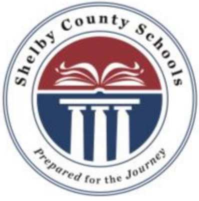

Lewis Brooks, Ed.D.
Superintendent

Child Nutrition Department

Account Refund Request

Email completed form to: mblankenship@shelbyed.org

Student Name: ______________________ **Date of Birth:** ____________

School Name: ______________________ **Reason for Refund:** ____________

Amount to be Refunded: $ ____________ (No refunds less than $5.00 will be processed)

Make Check Payable: Click to enter.

MAIL REFUND TO:

Street Address or PO Box: ______________________

City/State/Zip: ______________________

Parent/Guardian Name: ______________________

Contact Number: ____________ **Email:** ____________

☒ By completing this form, you are acknowledging the **Parent/Guardian E-Signature** as an electronic signature. You agree your electronic signature below is the legal equivalent of your manual signature on this form. The **Parent/Guardian E-Signature** constitutes accuracy and acceptance as if you signed the form in writing.

____

Parent/Guardian E-Signature **Date**

FOR ACCOUNTING PURPOSES

CENTRAL OFFICE USE ONLY								
12	**4**	**6710**	**000**		**5101**	**0**	**8420**	**0000**

CNP Coordinator's Signature