

Debit Lunch Program Account Balance Refund

Questions: Please call 262-376-5405

Responsible Party Last Name:	First Name:
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Student Last Name:	Student First Name:
Student Last Name:	Student First Name:
Student Last Name:	Student First Name:
Student Last Name:	Student First Name:

- I am requesting that I be refunded the remaining balance but I will not be closing the account.
- I am requesting that my meal program account be closed as of (date) _____ and any remaining balance be returned to me.

Responsible party signature: _____ Date: _____

My refund should be sent to the following address:

Name:		
Street:		
City:	ST:	Zip:

Allow 5-10 working days for processing. Please return this form via one of the following:

Debit Lunch Program
Grafton High School
1900 Washington Street
Grafton WI 53024

Email lbinder@grafton.k12.wi.us
Be sure to put "Balance Request"
in the subject line.

FAX 262-376-5410
Attn: Lunch Refund

Office use only below this line

I am requesting a refund for the above stated account because....

- Student(s) has left district
- Student(s) has graduated
- Payor's choice
- No longer employed by district

Refund amount:	\$
Refund removal date:	
Refund check number:	
Refund check date:	
Refund of cash given to:	
Account # 50R800251257000	

Coordinator's Signature Date

Business Manager's Signature Date