



Reynolds School District #7
Nutrition Services
1214 NE 201st Avenue
Fairview, OR 97024
Office: 503.661-7200

Parent Request for Refund of Student Meal Account Balance

****Can student balance be transferred to a older sibling? Yes/No. If yes, please call Kim Lindquist at the number above to make transfer. If no, please fill out request below.**

Today's Date: _____

Parent/Guardian _____

Name: _____

Mailing Address: _____

City: _____

State, Zip: _____

Phone: _____

Student Name(s): _____

Student ID #: _____

School(s) _____

Attended: _____

• Please refund the account balance for the above named student/account.

• Parent/Guardian Signature _____

Parents: Refunds via US mail for balances can take up to 10 business days. A check will be mailed to your home address.

*****For office use only*****

Date sent to NS Office _____

Balance W/D via Mealtime \$ _____ Date _____ Initials _____

Vendor Email _____ Date _____

Request to Business Office _____ Req. # _____ Date _____