



FOOD & NUTRITION REFUND REQUEST

PAYEE NAME _____ AMOUNT \$ _____
(PLEASE PRINT or TYPE) (Leave blank if unknown)

STUDENT NAME _____ STUDENT
NUMBER _____

SCHOOL NAME _____

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

REASON FOR REFUND REQUEST _____

Please select what you would like us to do with the money left in your account. If no box is selected, then a check will be sent to the payee at the address listed above.

☐ FULL REFUND TRANSFERRED TO: _____
Student's Name

School Name Student ID # or Birthday

☐ FULL REFUND ISSUED TO THE PAYEE AT THE ADDRESS LISTED ABOVE

☐ DONATE TO SCHOOL (To support students who need assistance paying for school meals)

Thank you for your request. Full refunds will be issued in 4-6 weeks. Transfer and donation requests will be processed within 48 hours of receipt. Once completed, use the submit button below or email to: foodservices@everettsd.org. If you have any questions please contact Food & Nutrition Services at: 425-385-4380 or email the address listed above.

FOR FOOD & NUTRITION AND ACCOUNTING USE ONLY

ACCOUNT CODE (BUDGET) _____

ORIGINAL RECEIPT # _____

RECEIVED BY _____ DATE _____

AUTHORIZED BY _____ DATE _____

ACCOUNTING NOTES: