SCHOOL NUTRITION PARENT REFUND REQUEST FORM

Please complete the information below. Please print legibly.

Reimbursement $ _____

Reason for Reimbursement:

_____

_____

Parent's Name: _____

Address: _____

Phone: _____

Child's Name: _____

Child's Student ID: _____

School site: _____

Parent's Signature: _____

Today's Date: _____

The Accounts Payable department processes reimbursement checks twice per week. All reimbursement checks are distributed by mail. Please allow 5-10 business days for your request to be processed.

Please return to: SNP Applications Center
Attn: Maria Fields
3609 Hopkins Street
Savannah, GA 31405

This institution is an equal opportunity provider.