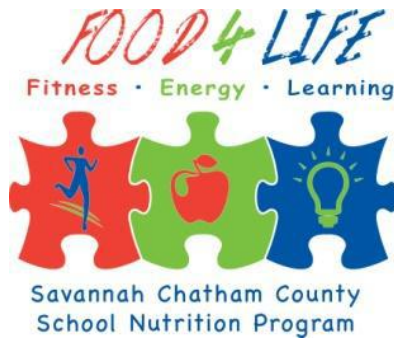


# SCHOOL NUTRITION PARENT REFUND REQUEST FORM



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.