CHILD NUTRITION DEPARTMENT

Cafeteria Account Refund Request

Student Name:_____ Student ID:_____

Student Grade: _____

Campus Name:_____

Refund check mailed to:

Parent/Guardian Name _____

_____

_____

_____

Reason you are requesting a refund:_____

Please allow **10 business days** in order for the Business Office to process your refund request. A parent/guardians signature is necessary to release the funds.

Parent/Guardian signature required:_____

OFFICE USE ONLY
Vendor Number:
Balance:
Date Processed:
Approval:

You may scan completed form to traci.campbell@giddings.txed.net or Fax to 979-542-9264