MEAL ACCOUNT REFUND REQUEST

Please complete form, sign form, and return to the Main Office.

All students leaving and not returning to Kalani High School must submit this form.

Print Name of Student: _____ ID #_____

Print Name of Parent/Guardian : _____ Phone _____

Check one:

___ I would like the refund monies mailed to me. (A self-addressed stamped envelope must be attached.) Allow 4 – 6 weeks processing time.

___ I will pick up the refund. My daytime contact phone number is _____.
OR a designated person, _____, will be picking up the refund.

___ I would like my child's meal account funds transferred to a sibling attending Kalani High School.
Print Sibling's Name: _____ ID# _____

___ I would like to donate the balance of my child's lunch account to Kalani High School.

Parent/Guardian Signature _____ Date _____

Revised: 9/25/2015

(For Office Use Only)

Date refund picked up: _____ Recipient 's Signature _____

Print Name/Relationship to Student: _____

Date refund mailed: _____ Check no. _____ Refund Amt. _____