Debit Lunch Program
Account Balance Refund

Questions: Please call 262-376-5424

Responsible Party Last Name:	First Name:

Student Last Name:	Student First Name:
Student Last Name:	Student First Name:
Student Last Name:	Student First Name:
Student Last Name:	Student First Name:

☐ I am requesting that I be refunded the remaining balance but I will not be closing the account.

☐ I am requesting that my meal program account be closed as of (*date*) and any remaining balance be returned to me.

Responsible party signature: _____Date: _____

My refund should be sent to the following address:

Name:		
Street:		
City:	ST:	Zip:

Allow 5-10 working days for processing. Please return this form via one of the following:

Debit Lunch Program
Grafton High School
1900 Washington Street
Grafton WI 53024

Email kwall@grafton.k12.wi.us
Be sure to put "Balance Request" in the subject line.

FAX 262-376-5414
Attn: Lunch Refund

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Office use only below this line **********

I am requesting a refund for the above stated account because….

- ☐ Student(s) has left district
- ☐ Student(s) has graduated
- ☐ Payor's choice
- ☐ No longer employed by district

Kari Wall
_____
Coordinator's Signature *Date*

Refund amount:	**$**
Refund removal date:	
Refund check number:	
Refund check date:	
Refund of cash given to:	
Account # 50R800251257000	

_____
Business Manager's Signature *Date*

Rev. 8/2019