

MEAL ACCOUNT REFUND/TRANSFER OF FUNDS REQUEST

Student's Name: _____ Grade _____

Student's 9-Digit ID Number: _____ School _____

Parent's Name: _____

Phone Number: Hm: _____ Wk: _____ Cell: _____

Mailing Address: _____

City, State, Zip Code: _____

Reason for Refund:

Graduated

Transfer Outside District

Other, Explain _____

Transfer funds to: Sibling's Name _____ Grade _____

Sibling's ID# _____ Sibling's School _____

Please note that a student's meal account money is automatically carried over to the next school year **EXCEPT** after completion of the 12th grade. If your child will not be attending a school within the Long Beach Unified School District his/her money will be transferred to the youngest sibling in your family or refunded after completion of this form. Please allow 30 days for your request to be processed. Please contact the Nutrition Services Branch office at (562) 427-7923 if you have any questions or need clarification.

Date: _____

Signature of Parent/Guardian

Parents: Fill out this form completely. Sign it and mail to or fax to (562) 988-0263:

**Long Beach Unified School District
Nutrition Services Branch
3333 Airport Way
Long Beach, CA 90806
Attention: Operations & Training Specialists**

Office Use Only: Amount Refunded/Transfer: \$ _____

Verified: _____ Date: _____
Operations & Training Specialist