



Yuba City Unified School District

STUDENT NUTRITION SERVICES

REQUEST FOR REFUND

NAME OF STUDENT _____ DATE _____

STUDENT BALANCE _____ ID NUMBER _____

SCHOOL _____

REFUND TO:

Parent or Guardian _____

PLEASE PRINT

Address _____

Telephone # _____

Signature of Parent Requesting Refund _____

PLEASE RETURN THIS FORM TO THE ADDRESS LISTED BELOW:

STUDENT NUTRITION
730 GRAY AVENUE
YUBA CITY, CA 95991

OR EMAIL TO: *achima@ycusd.org*

Questions regarding this form, please call the Student Nutrition Office at (530) 822-5078

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Do not complete for office use only

Refund Processed on _____

Approved By: _____

Budget Code: _____