

**BERRYESSA UNION SCHOOL DISTRICT
STUDENT NUTRITION SERVICES**

PARENT TRANSFER/REFUND REQUEST FORM

Date: _____

Student Name: _____ **School:** _____ **Student #:** _____

**If student is now in high school:*

School Attended _____ *Current Grade* _____ *Balance if known:* _____

☐ **I would like to request that the balance of my child's account be *transferred* to his/her sibling(s):**

Name: _____ School: _____ Student #: _____ Amount: \$ _____

Name: _____ School: _____ Student #: _____ Amount: \$ _____

☐ **I would like to request a *partial* refund of \$ _____ from my child/children's cafeteria account.**

☐ **I would like to request a *full* refund for the balance of my child/children's cafeteria account.**

Reason for Refund:

Parent Name: _____ **Phone #:** () _____

Address: _____

Parent Signature: _____

Method of Payment for Refunds:

- Turn in request to School Office, District Office or Mail to:
Student Nutrition Services, 951 Piedmont Road, San Jose, CA 95132
- E-mail request to SNS@busd.net
- Account balance(s) will be verified by Student Nutrition Services.
- A refund of greater than \$20 will be paid by **check** issued by the District. You will receive the check by mail within 2-3 weeks.
- A refund of \$20 or less can be paid in cash by the school cafeteria **for students who are currently enrolled in the district.**