Food Service Department
#1 Civic Center Circle, 2nd Floor
Brea, CA 92821
714-990-7805

Meal Account Refund/Transfer Request

Purpose of submitting this form:

☐ Requesting a refund – Over $5.00

☐ Requesting funds be transferred to a sibling

Student's School: ____

Student's Name: ____

(If Transfer) Transfer to Sibling:

Sibling's Name: ____

Sibling's School: ____

(If Refund)

Make Refund Check Payable To: ________________________________

Mail Refund Check to: ____________________________________

City, State, Zip: ____

Phone Number where you can be reached: __________________________

Reason for Transfer/Refund: ___________________________________

Please note that a student's meal account money is automatically carried over to the next school year EXCEPT after completion of 12th grade. If your child will no longer be attending a school within the Brea Olinda Unified School District, please notify our office. No refund is required for maintaining the meal account balance through the next school year.

____
(Printed Name of Parent/Guardian)

____
(Signature of Parent/Guardian)

Date: ______________________

For District Use Only:

Received ___________

Processed __________