Madison-Grant United School Corporation
Nutrition Department

Request for refund of meal account funds

Student Information:

Name(s) ____

School(s) ____

Reason for refund (circle):

Left school district Graduated Other (specify) ____________________________

Anticipated amount of refund: __________________________

Please indicate where you want the check mailed:

Parent/Legal Guardian to make payable to ____

Phone: _______________________

Address: __________________________ City, State, and Zip: _________________________

SIGNATURE ____ **DATE** ____________

Please submit form to:
Madison-Grant High School
ATTN: Food Service Department
11700 S E00 W
Fairmount, IN 46928

All refunds are in form of a check. Please allow 1-2 weeks for processing. In the event that the actual refund amount differs from the anticipated amount, the person who completed this form will be contacted. Any questions, please contact the Food Service Director's office at 765-948-4141.