INTERNATIONAL LEADERSHIP OF TEXAS
CHILD NUTRITION DEPARTMENT
REQUEST FOR REFUND OF PREPAID ACCOUNT

School _____ Date _____

STUDENT'S NAME	STUDENT'S ID #	AMOUNT

MAKE CHECK PAYABLE TO:	
PARENT'S NAME	
CURRENT PHONE NUMBER	
STREET ADDRESS (Address must match Skyward, otherwise refund won't be made)	
CITY, STATE, ZIP CODE	

Must be verified by cashier or manager.
Manager/cashier initials _____

Mail Request to:

Student Nutrition Office
1601 Summit Ave. #110
Plano, TX 75074

Or email to:

childnutrition@iltexas.org
Subject: Refund Request

Refund will be mailed.

Parent Signature _____
Payment will not be made without signature

This institution is an equal opportunity provider.