



PARK CITY

EDUCATIONAL EXCELLENCE

SCHOOL DISTRICT
CHILD NUTRITION DEPARTMENT

2700 KEARNS BOULEVARD
PARK CITY, UTAH 84060

435/645-5600
435/645-5609 FAX

Date: _____

Please note that your child's lunch balance will transfer to the next school year; however, if you would like a refund or transfer funds between siblings, please fill out the form below.

TRANSFER OF FUNDS TO SIBLING REQUEST

I, (parent/guardian) _____, request a transfer of funds from
(student) _____ to (student) _____ at (school) _____.

OR

REFUND REQUEST

I, (parent/guardian) _____, request a refund for (student) _____ grade _____ at
school _____, from the Park City School Child Nutrition Department for the following reason
_____.

Please send the refund to the following address:

Name

Address

City, State, Zip

Parent/Guardian's Signature

Please mail or fax this form to the Park City School District, attention Child Nutrition Department. If you have any questions, please contact us at 435-615-0204.

Thank you.

Kathleen Britton

Kathleen Britton
Director-Child Nutrition Department

For Accounting Department

Refund Payable to: _____
Student/Staff: _____
Home Address: _____

Account Number : 5 8001R41610
Transaction Posted to Nutrikids Y or N
Account Transaction Attached Y or N

School: _____
Amount: _____

Authorization Signature _____