



Lewis Brooks, Ed.D.
Superintendent

**Child Nutrition Department
Account Refund Request**

****Please print or type****

Once completed **and** signed,
FAX form to 205-682-6526 or
EMAIL form to mblankenship@shelbyed.org

Student Name: _____

Reason for Refund: _____
(No refunds for less than \$5.00 will be processed)

Make Check Payable to: _____

Mail refund to:
Street or PO Box _____
City/State/Zip _____

Parent/Guardian Signature Date

Cell Phone Number Home Phone Number

Amount to be Refunded: _____
****No refunds for less than \$5 will be processed.****

CNP Manager's Signature: _____
****Account balance printout should be attached.****

During the summer months (when CNP Manager is off contract) a designee
from the
CNP Central Office will
sign: _____

School Name: _____

Principal's Signature CNP Coordinator's Signature

CENTRAL OFFICE USE ONLY								
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410 East College Street
Post Office Box 1910
Columbiana, AL 35051

(205) 682-7000 Phone
(205) 682-7005 Fax

www.shelbyedk12.al.us