KINGSBURY PARK DISTRICT
REFUND REQUEST FORM

Medical Refund_____ Regular Refund_____

Name _____
(Last) (First)

Participant's Name_____
(Last) (First)

Address_____

City_____ Zip Code_____

Phone Number_____

Activity_____

Reason For Refund Request_____

_____

If Medical Refund is requested, attach copy of dated medical document.

_____
Signature of Parent or Legal Guardian Date

For Office Use Only

Amount Paid for Activity_____ Amount of Refund_____

Full_____ 80%_____ 50%_____ Request Denied_____

Reason Request was Denied_____

_____