

# Barrington Park District Refund and Transfer Request Form

**Office Use Only**  
Date Stamp: \_\_\_\_\_  
Received by Front Office \_\_\_\_\_

Please fill out this form completely and mail or fax it to:  
Barrington Park District, 235 Lions Drive, Barrington, IL 60010 FAX: 847-381-8794

**All refunds and transfers are subject to a 10% administrative service fee. All Preschool, K.E.E.P & Ski Club registration fees are NON-REFUNDABLE.**

A request for a refund/transfer must be received a minimum of five business days prior to the first day of class. Some programs may qualify for a prorated refund, if due to an injury or illness accompanied by a doctor's note. The refund will be based on the number of classes attended and the date the refund request is received. Enrollments paid by cash, check or credit card will be refunded by check. Refunds will be mailed to participants approximately 2-3 weeks after approval is received.

**To be filled out by Participant or Parent/Guardian:**

|                                   |      |            |
|-----------------------------------|------|------------|
| Participant (First and Last Name) | ( )  | Home Phone |
| Street Address                    | City | State Zip  |
| Participant or Parent Signature   | Date |            |

## REFUNDS

Activity name currently enrolled in: \_\_\_\_\_  
Activity # \_\_\_\_\_ Sec. # \_\_\_\_\_ \$ Fee Pd. \_\_\_\_\_ No. of classes attended \_\_\_\_\_

**Please indicate reason for refund:**  Conflict  Medical (Doctor's note is required)  Other: Explain \_\_\_\_\_

## TRANSFERS

Activity name currently enrolled in: \_\_\_\_\_  
Activity # \_\_\_\_\_ Sec. # \_\_\_\_\_ \$ Fee Pd. \_\_\_\_\_  
Activity name to be transferred to: \_\_\_\_\_  
Activity # \_\_\_\_\_ Sec. # \_\_\_\_\_ Class fee \_\_\_\_\_

## Payment for Difference in Class Fees

To calculate the amount of your payment, calculate the difference between the fee for your original class and the fee for the class you are transferring into. Then, add the 10% transfer service charge.

Total Fee \_\_\_\_\_ Method of Payment:  Cash  Check  Credit Card (circle one): VISA or MC  
( ) / /  
Account # \_\_\_\_\_ Expiration Date \_\_\_\_\_  
Cardholder Name (please print) \_\_\_\_\_ Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please indicate reason for refund:**  Conflict  Medical (Doctor's note is required)  Other: Explain \_\_\_\_\_

### For Office Use Only:

|  |   |
|--|---|
| <b>Refund/Transfer</b>                   | Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, but prorated |
| If No, Reason: _____                     |   |
| If medical, # of classes attended: _____ | Notes _____   |
| Total Fee Paid \$ _____                  | Supervisor _____  |
| Fee of Transferred Activity \$ _____     | Date submitted _____  |
| Less Misc Fee \$ _____                   | Staff follow-up phone call _____  |
| Less Service Fee (10%)\$ _____           | Refund/Transfer Entered by _____  |
| Total Refund/Amount Due \$ _____         | Date _____ By _____   |