Child Nutrition Services

Application for School Meal Refund/Transfer

Travis Unified School District
Child Nutrition
2751 De Ronde Drive Fairfield,
CA 94533-9710

Date of Request: _____ Name of Parent/Guardian: _____

Physical Street Address:_____

Email: _____ Phone: _____

Refund: List all students in household needing a refund

Student Name	School Name	Grade	Refund Requested ($)

Reason for Refund: _____

Transfer: Complete each blank space to transfer funds from one student's account to another

Transfer Amount: $_____ From (student): _____ To (student): _____

Parent/Guardian Signature: _____

District Use Only

Last Day Attended: _____

Total Amount Refunded: _____

Authorized Signer: _____ Date: _____