



STUDENT TRANSPORTATION REQUEST

PLEASE TYPE OR PRINT AND FILL IN ALL INFORMATION

Incomplete Forms Will Be Returned

District To Be Billed: _____ SUMMER _____

Student's Name: _____

Sex: _____ DOB: _____ Grade: _____

Street Address: _____ Town: _____ Zip: _____

Mailing Address: _____ Town: _____ Zip: _____

Nearest Intersection To Residence: _____

Parent's Name/Guardian: _____ Telephone# _____

Emergency Contact Name: _____ Telephone# _____

Any Additional contact Names/Numbers: _____

Receiving School: _____

CONTACT PERSON _____ Telephone Number: _____

School Address: _____

Days Of Week (Circle) M T W T F (please include a calendar)

Service To Begin: _____ Service To End: _____

School Hours: _____ Earliest time for drop off: _____

FILL IN BELOW FOR SPECIAL NEEDS STUDENTS:

Student Special Needs: (Please check/specify)

Classification: _____ Seat Belt: _____

Safety Restraint System: _____ what type: _____ Wheelchair Lift/Ramp: _____

Car Seat: _____ Booster: _____ Child's Weight: _____ Child's Height: _____

Aide: _____ If Yes, Supplied By District: _____ Contractor: _____

Special Requirements for Aide: _____

Additional information pertinent to a Safe Trip _____

We have reviewed and supplied the above information:

Case Manager: _____ Phone: _____ Fax: _____

CST Coordinator / Director
Date: _____

Board Secretary / Business Administrator
Date: _____

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