

TRANSPORTATION REQUEST FOR
CHILD CARE SERVICES FOR THE

[REDACTED] **SCHOOL YEAR**

PHONE: (845)615-6700

FAX: (845)615-6707

CHILD'S NAME: _____ **DOB:** _____

SCHOOL: _____ **GRADE:** _____

HOME ADDRESS: _____

EFFECTIVE DATE OF CHILD CARE SERVICES: _____

WHAT DAYS (PLEASE CIRCLE): M-TU-W-TH-F AM - PM OR BOTH

**** CHILD CARE WILL ONLY BE PERMITTED ON A CONSISTENT BASIS ****

**** NO ONE DAY CHANGES ARE ALLOWED FOR THE SAFETY OF YOUR CHILD ****

PICK UP ADDRESS: _____

DROP OFF ADDRESS: _____

PARENT NAME: _____

CHILD CARE PROVIDER NAME: _____

CONTACT NUMBERS: **PARENT HOME:** _____

PARENT CELL: _____

CHILD CARE PROVIDER HOME: _____

CHILD CARE PROVIDER CELL: _____

EMERGENCY CONTACT: _____

PARENT SIGNATURE: _____ **DATE:** _____

TRANSPORTATION OFFICE USE ONLY

TO SCHOOL ROUTE: _____ BUS STOP LOCATION: _____ TIME: _____

FROM SCHOOL ROUTE: _____ BUS STOP LOCATION: _____ TIME: _____