



Transportation Request

Parents Names: _____

Address: _____

Phone: _____ **Cell:** _____

Students Requiring Bus Transportation	Grade	Medical Conditions/Special Needs/Allergies

Please indicate your requirements by circling the days and times below:

		Monday		Tuesday		Wednesday		Thursday		Friday	
	Full Time 6 or more rides per week	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
	Part Time Up to 5 rides per week	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM

Scheduled occasional bus service is also available; please give us the details of your request:

I/We acknowledge that we have read, understood and agree to the Conditions of Service (attached) and discussed it with my/our child(ren). I/We share CCS' commitment to student safety and conduct and also accept the responsibility of the financial obligations for transportation.

Signature _____

Signature _____

Date _____