Stockbridge Valley Central School District
Kindergarten Transportation Request Form

Student Name: ____

Health Issues/Accommodation Driver should be aware of: ____________________________

Location #1 – Home Address *

Parent/Guardian(s) Name:______________________________Relationship:____________

Address: ____

Phone: __________________(H) __________________(C) __________________(W)

Brief Description of home and location: ____________________________________

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Location #2 – Alternate Address *

Parent/Guardian(s) Name:______________________________Relationship:____________

Address: ____

Phone: __________________(H) __________________(C) __________________(W)

Brief Description of home and location: ____________________________________

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Please indicate below where your child will be transported to and from each day (Location #1 or Location #2) or if you will be transporting your child.

Monday AM: _______________ PM: _______________ Parent Transport: AM or PM

Tuesday AM: _______________ PM: _______________ Parent Transport: AM or PM

Wednesday AM: _______________ PM: _______________ Parent Transport: AM or PM

Thursday AM: _______________ PM: _______________ Parent Transport: AM or PM

Friday AM: _______________ PM: _______________ Parent Transport: AM or PM

Parent/Guardian Signature: ______________________________Date: ____________