ST. CLAIR COUNTY BOARD OF EDUCATION

EXTRACURRICULAR BUS TRIP SCHEDULE/PERMISSION FORM

TRANSPORTATION DEPARTMENT – PHONE (205) 629-6255

This form **MUST BE** completed for **ALL** requests for the use of a bus for any trip.

Each form **MUST INCLUDE** the following:

- Be completed in detail
- Approved by the principal
- School nurse must be notified to verify any student medical needs
- Special education representative to verify any special transportation needs
- A map with directions

Please email your request to Amiee Price at linda.price@sccboe.org in the Transportation Department **at least 10 days prior** to date of trip to provide ample time for approval and scheduling. A completed form with approval and bus assignment will be emailed prior to trip. Upon emailing a request, please call 629-6255 to confirm that your request was received.

If a day trip, buses must be back at the school by 2:30.

NOTE: In the event of a cancellation, it is the responsibility of the Contact Teacher to advise **(**within a reasonable time frame) the Transportation Department of the cancellation. Please send cancellation request via email to Amiee at linda.price@sccboe.org.

DATE OF REQUEST: _____

DATE(S) OF TRIP: (**For non-consecutive dates, please submit separate request for each date**): _____

SCHOOL: _____

CONTACT TEACHER: _____ CELL NUMBER: _____ EMERGENCY CONTACT NUMBER: _____

TEACHER(S) ATTENDING: _____ Activity # (for Bookkeeper): _____

NUMBER SCHEDULED TO ATTEND: Students: _____ Teachers/Admin: _____ Chaperones: _____

(Roster of students, staff, and chaperones must be attached AND provided to school administration)

MODE OF TRANSPORTATION: # of Regular Buses: _____ # of Special Needs Buses: _____Charter Bus (# of buses): _____Other:_____

MILEAGE TO BE PAID BY: _____

NUMBER OF MILES FROM SCHOOL TO DESTINATION PER ATTACHED MAP: _____

DESTINATION: _____

BUS DRIVER(S) FOR TRIP: _____

APPROXIMATE TIME BUS IS SCHEDULED TO LEAVE: _____ RETURN TO SCHOOL: _____

OBJECTIVES OF TRIP:

_____

_____

ITINERARY **(In detail)**:

_____

_____

APPROVAL:

PRINCIPAL: _____ DATE: _____

DISTRICT OR SCHOOL NURSE: _____ DATE: _____

SPECIAL EDUCATION REPRESENTATIVE: _____ DATE: _____

(Only required if there are special transportation or toileting needs)

SUPERINTENDENT: _____ DATE: _____

(Only required for ANY out-of-state OR overnight trips)

TRANSPORTATION DIRECTOR/DESIGNEE _____ DATE: _____

TO BE COMPLETED BY THE TRANSPORATION DEPARTMENT:

BUS(ES) ASSIGNED: _____

Date request was received: _____ Date assigned and returned to school: _____

Trip cancelled (via email) per: _____ Date of cancellation: _____