

Emergency Information Card - Page two

Student's Name: _____ Birthdate ____/____/____
 Address: _____ Apt: _____ City: _____ Zip: _____
 Mailing address (if different) _____ City: _____ Zip: _____
 Student lives with (Please indicate your relationship: Parent, Guardian, Relative, Group home staff)
 Name Relationship Languages Spoken work phone

1. _____
 2. _____

Alternate pick-up/drop off Locations: If you would like the bus to regularly pick-up or drop off your child at a care givers address or another location other than your child's home, please provide the information below.

A.M. Pick-up: Responsible Adult's Name: _____
 Relationship to child: _____
 Address: _____ Apt: _____ City: _____ Phone: _____
 P.M. Drop off: Responsible Adult's Name: _____
 Relationship to child: _____
 Address: _____ Apt: _____ City: _____ Phone: _____
 Languages spoken: _____

Emergency Pick-up: (for all students) If your child is ill or injured, you must pick up your child from school immediately. In case you cannot be reached, list two individuals who will be able to pick up your child.
 Name Relationship Languages spoken Daytime phone

1. _____
 2. _____

Emergency Bus drop off: You are responsible for being present to assist your child at the bus door each morning and afternoon as your child boards and exits the bus, unless a Request for Bus Procedure Change has been approved. List two individuals (not living with you) who will receive your child from the bus if you are not at home. These individuals must be in your neighborhood, and must be notified of this responsibility. In the event that no adult is available to supervise your child, your child will be returned to school, school officials will contact Child Protective Services if no one can be contacted.
 Name Street Address City Daytime phone

1. _____
 2. _____

Parent's / Guardian Signature: _____ Date: _____
 When this information changes, inform the Transportation Department and your child's teacher so bussing will not stop. Please note that bus schedules are subject to frequent change.

----- For Office & Program Staff Use Only -----

Driver: AM _____ PM _____ Route # _____
 Estimated time of pick-up _____ Estimated time of drop off _____
 Form received in Transportation: Time _____ by Whom _____
 Form reviewed by Special Ed Department: Date: _____ by Whom _____
 CC to: Transportation Department, School Nurse, Special education Department