SOUTH COLONIE TRANSPORTATION DEPARTMENT

2 Winston Place, Albany, NY 12205
Phone (518) 869-8527 Fax (518) 869-0355

NON-PUBLIC SCHOOL
ANNUAL TRANSPORTATION

MUST BE RETURNED TO SOUTH COLONIE TRANSPORTATION DEPT. BY APRIL 1ST

PLEASE PRINT!

Date ___/___/___

School Name_____

Student Name _____ (Last) _____ (First)

Home Address _____ (House #) _____ (Street Name) _____ (Apt. #)

Grade _____ _____ (City), New York 12_____ (Zip Code)

Home Phone #_____ Birth Date___/___/___ (M D Y) Sex M or F (Circle One)

Contact Information:
Parents:

_____ (Mother's Last Name) _____ (Mother's First Name) _____ (Work Phone #)

_____ (Father's Last Name) _____ (Father's First Name) _____ (Work Phone #)

Guardian_____ (Guardian's Last Name) _____ (Guardian's First Name) _____ (Guardian's Work Phone #)

Please schedule my child for transportation:

☐ AM Only ☐ PM Only ☐ Both AM & PM

(Please check one of the above boxes)

Students may be picked up or dropped off at **APPROVED** child care locations if the request is received at the transportation department by April 1. However, pick-up and/or drop-off must occur at the **SAME ADDRESS** for **all** five days of the week and be **within** district boundaries.

AM Pick-Up Address _____ (House #) _____ (Street Name)

PM Drop-Off Address _____ (House #) _____ (Street Name)

Daycare Provider: _____ Phone # _____

I have read and understand all of the information provided on this transportation request form. I certify that I am a resident of the South Colonie School District and am entitled to receive transportation services. I understand that this request is required to be turned in by April 1 of each year or within 30 days of establishing district residency.

_____ Date ___/___/___
Signature of Parent/Guardian

District Use

STAMP DATE RECEIVED

White - Transportation Copy Yellow - Parent Copy