

# SHARPSVILLE AREA SCHOOL DISTRICT BUS REASSIGNMENT REQUEST

Date of Request \_\_\_\_\_

Reassignment of bus stop to begin on \_\_\_\_\_  
*(3 working days' notice from Date of Request)*

S T U D E N T	Student Name: _____
	Student Grade: _____
	Student Home Address: _____
	Student Home Phone: _____

M O R N I N G	The above named student needs transportation <b>to school</b> from the following location Address: _____
	Name of person who lives at this location: _____
	Phone Number at this address: _____
	<b>PLEASE NOTE: The student MUST be picked up at this location Monday through Friday. This will be your child's ONLY BUS STOP.</b>
	Parent/Guardian Signature _____

A F T E R N O O N	The above named student needs transportation <b>from school</b> to the following location Address: _____
	Name of person who lives at this location: _____
	Phone number at this address: _____
	<b>PLEASE NOTE: The student MUST be dropped off at this location Monday through Friday. This will be your child's ONLY BUS STOP.</b>
	Parent/Guardian Signature _____

**PLEASE NOTE:** This reassignment will become the only bus your child will ride throughout the school year. If alternate arrangements become necessary, please contact Barbara Dunlap at 724-962-8300, extension 4102.