

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 <u>to school</u> from the following location Address:
	Name of person who lives at this location:
	Phone Number at this address:
	PLEASE NOTE: The student MUST be picked up at this location Monday through Friday. This will be your child's ONLY BUS STOP.
	Parent/Guardian Signature _____

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