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)

STUDENT	Student Name:
	Student Grade:
	Student Home Address:
	Student Home Phone:

MORNING	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 _____

AFTERNOON	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 Stephanie Bobovnyk at 724-962-8300, extension 4102.