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

The above named student needs transportation **to school** 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 ______________________________

The above named student needs transportation **from school** 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.