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Alternate Transportation Request

••••••	•••••• Student Information	ation ·····
Student Name:		Grade:
Parent/Guardian Name: _		
Legal Home Address:		
Home Phone: Cell Phone:		:
School Attending:		
•••••	······ Child care Provider I	nformation ······
Name of provider:		Licensed with DSS? ☐ Yes ☐ No
Provider Address:		
Description/Geographical	location of facility:	
Telephone Number:		
School zone of provider: _		
Alternate transportation is required: (Start date) (End date)		
Transportation needed: A	M: PM: ☐ Yes ☐ No ☐ Parent Transport	☐ Yes ☐ No ☐ Parent Transport
Parent/Legal Guardian Signature:		Date:
PLEASE RETURN TO OU	JR OFFICE - Fax: (315) 341	-2918 - Email: jvangord@oswego.org
••••••	Office use or	nly ••••••
☐ Request Approved	☐ Request Denied	Effective Date:
Reason for Denial:		
AM Route: Bus	Stop:	
PM Route: Bus	Stop:	
		Received by: