17511 North Main | Galesville, WI 54630 | p: (608) 582-4657 | f: (608) 582-4961 | www.getsd.org

TRANSPORTATION FORM

PHONE (608) 582-4657 * FAX (608) 390-3053

PLEASE RETURN ONE FORM PER HOUSEHOLD TO REQUEST TRANSPORTATION FOR THE NEXT SCHOOL YEAR by JUNE 1st or ASAP.

1. **Your child's pickup and drop off location must be the same each day with one optional location allowed in an area served by your child's school. Attendance boundary information is available in the District Office or call 582-4657.**
2. **Transportation outside of these locations will be the responsibility of the parent or guardian. Only assigned students may ride route buses.**
3. **It is very important that you keep your address information current. If you notify us of changes less than 2 weeks before school begins, you may need to transport your own child until arrangements are completed for school transportation.**
4. **Deliver this request ASAP to your school office. If school is not in session, deliver or mail form to the School District Office 17511 N Main St Galesville WI 54630.**
5. **You will receive a written confirmation of transportation requested before the start of school.**

(Please Print)

_____ _____ _____

Parent / Guardian Last Name First Name Signature

STUDENT INFORMATION

Student Last Name	First Name	School /Grade	Male/Female

_____ I do **not** need transportation services for the children listed above. **STOP HERE**

_____ I **do** need transportation services for the children listed above: _____ Date to Begin

_____ **to and from home only. Address** _____ **STOP HERE**

MORNING PICKUP LOCATION-TWO LOCATIONS ☐ **AFTERNOON SAME AS BELOW**

PRIMARY _____ _____ _____ _____

House # Street Name Unit # City Phone

Care Providers Name _____

OPTIONAL _____ _____ _____ _____

House # Street Name Unit # City Phone

Care Providers Name _____

AFTERNOON DROP OFF LOCATION-TWO LOCATIONS Complete Only if Different for Afternoon

PRIMARY _____ _____ _____ _____

House # Street Name Unit # City Phone

Care Providers Name _____

OPTIONAL _____ _____ _____ _____

House # Street Name Unit # City Phone

Care Providers Name _____