CB TRANSPORTATION AGREEMENT

Center___________________________ **Class #**________________

Teacher__________________________

( ) I want the Head Start Program to transport my child (ren)

( ) I do not need transportation services

Child's Name___________________________ Parent/Guardian's Name___________________________

Home Phone #________________________ Work Phone #__________________________________

Cell Phone #__________________________

Children will be picked up and returned only to the addresses listed below.

Pick-Up Address____

(Street) (Town) (Phone #)

Finding directions from the Center to the child's pick-up point. Please include names of streets and approximately blocks plus any landmarks, description of the house and what side of the street is it on.

____

____

____

Drop-Off Address____

(Street) (Town) (Phone#)

Finding directions from the Center to the child's drop-off point. ________________________________

____

____

____

I CERTIFY THAT I HAVE READ THE TRANSPORTATION GUIDELINES AND THEY HAVE BEEN EXPLAINED TO ME.

Parent/Guardian Signature____Date______________

Staff Signature____Date______________

Copy and give completed form to Transportation Staff and the Original goes to the Site Supervisor.