

Child's Name _____

Grade in School

Parent's Names

Home Address _____

Home Telephone

Mom's Work Phone _____ Dad's Work Phone _____

Allergies/Special Needs

Daycare Provider

Daycare Address

Child will be transported **from:** Home Daycare

Child will be transported to: Home Daycare

Child will ride on

M Tu W TH F

My child will begin riding on _____ (date) and will need rides as follows:

Both AM & PM for all day school, AM only, PM only

Morning Pre-school to & from _____ Afternoon Pre-school to & from _____

Other: _____

The daily rate for riding the bus is \$3.00 per day per child. Please make checks payable to **CTL BUS FUND**. For questions please call **Gene Valentien** at **496-4069**. Registrations should be mailed prior to the start of school to:

Gene Valentien, 27842 469th Ave., Lennox, SD 57039.

Please sign the **Emergency Medical Treatment Authorization** below:

I hereby give my permission for emergency medical treatment if deemed necessary by the bus driver on duty.

Parent Signature _____ Date _____

Parent Signature _____ Date _____