**BEDFORD CENTRAL SCHOOL DISTRICT**

**2023-2024 - APPLICATION FOR ALTERNATE STOP/DAY CARE TRANSPORTATION**

Please fill out the information below ⦁ One form per child ⦁ Mail, email or fax the completed form to:

**Bedford Central School District, Transportation Department,**

**PO Box 180, Mount Kisco, NY 10549**

**email to** **mconnolly4684@bcsdny.org** **or** **jtidmus3552@bcsdny.org**

**For information call the Transportation Department at 914-241-6001 / Fax 914-244-3475**

School Attended: ……..……………………..……………………………………………………………..

Students Full Name: …………………………………………………….   Grade: ...…………….…..…

Program Name: …..………………………………………………………………………………………..

Alternate Stop Address: ………..…………………………………………………………………………

Town: ..…………………………………..   Phone # at Program: ……..………………………………..

Contact Person at Program: ………….…………………………………………………………………..

**Please check the days you need transportation:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| **AM****[   ]** | **PM****[   ]** | **AM****[   ]** | **PM****[   ]** | **AM****[   ]** | **PM****[   ]** | **AM****[   ]** | **PM****[   ]** | **AM****[   ]** | **PM****[   ]** |

Parent / Guardian Name: …………………………………………………………………………………

Parent / Guardian Signature: ………..…………………………………………………………………...

Home/Cell: ………….……………………..…………  Work: …………...………………………………

Email: ……………………………………………………………………………………………………….

This form must be submitted prior to July 15th to be in place for the start of the school year. If submitted after July 15th or after the start of the school year, please allow 2-3 days for processing.