Fairfield Area School District

School Year: 2026-2027 Transportation Request Form

Please Check One:

_____ I request the FASD to transport my student(s) to _____

_____ I do **NOT** wish to request transportation from the FASD at this time.
(Please complete top portion only)

_____ AM _____ PM Please Check

Student(s) Name: _____ Birth Date_____

Parent/Guardian Name: _____ Grade _____

Address: _____

City _____ State _____ Zip _____

Home Phone No._____ Cell Phone No. _____ Work Phone No. _____

E Mail Address _____

EMERGENCY CONTACT INFORMATION: In the event of an emergency, such as an early dismissal due to inclement weather, please list an alternate person to pick up your child.

Alternate Name _____ Phone No(s). _____

Address _____ Relationship to Student _____

City _____ State _____ Zip _____

MEDICAL CONDITION: Does the student have a medical condition that the school district and/or bus driver should know about? **Yes ____ No _____**

If yes, please explain

_____

**PLEASE RETURN THIS FORM TO FAIRFIELD SCHOOL DISTRICT,
TRANSPORTATION DEPARTMENT, 4840 FAIRFIELD ROAD, FAIRFIELD PA 17320**