

C.R. WEEKS ELEMENTARY SCHOOL
BUS CHANGE REQUEST

STUDENT FIRST & LAST NAME		TEACHER	
		TEACHER	
		TEACHER	

PLEASE ALLOW
STUDENT(S) LISTED
ABOVE TO RIDE BUS#

**ALL SECTIONS MUST BE FILLED
IN FOR A BUS PASS TO BE ISSUED**

TO: _____

FULL NAME AND ADDRESS OF WHERE CHILD WILL BE TAKEN

ON (DATE(S)) _____

SIGNATURE OF
PARENT/GUARDIAN: _____

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