

Preschool: Alternate Destination

Child's Name: _____

Child's Classroom at Kid's Haven: _____

Destination: _____

Destination's Phone Number: _____

Transportation (please check one): Trailblazer Vision Head Start

Other: _____

Time to be picked up from Kid's Haven: _____

Time to be dropped off at Kid's Haven: _____

Days (please check all that apply):

<input type="checkbox"/>	Monday	<input type="checkbox"/>	Tuesday	<input type="checkbox"/>	Wednesday	<input type="checkbox"/>	Thursday	<input type="checkbox"/>	Friday
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Starting Date: _____

Ending Date: _____

Parent Signature: _____ Date: _____

Parent's Daytime Phone Number: _____

Please note: Your account will be charged \$2.50 for a transportation fee per day of transportation. If your child has an IEP/IFSP and their team has recommended them for special services at the school, this fee will be waived.

Please return to Kid's Haven office