



ST CHARBEL'S COLLEGE LIMITED

A Co-Educational Independent Catholic School K-12
ABN 44 642 594 045

SCHOOL BUS APPLICATION AND/OR VARIATION FORM

1. STUDENT DETAILS

STUDENT NAME	DATE OF BIRTH	CLASS
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

2. CONTACT DETAILS

Address: _____

Suburb: _____

Home Phone: _____ Email: _____

Mother's Name: _____

Work Phone: _____ Mobile: _____

Email: _____

Father's Name: _____

Work Phone: _____ Mobile: _____

Email: _____

4. TRANSPORT DETAILS

Transportation is required for (please choose from the following)

- Monday – Friday (Morning AND Afternoon)
- Monday – Friday (Morning ONLY)
- Monday – Friday (Afternoon ONLY)

Morning Pick Up Address: _____

Afternoon Drop Off Address: _____

5. AGREEMENT

I have read and agree to the Bus Rules that apply for the use of the College buses.

Parent's Signature: _____ Date: _____