WEST ISLIP TRANSPORTATION DEPARTMENT

100 SHERMAN AVENUE
WEST ISLIP, NY 11795
PH: (631) 893-3300 FAX: 631-893-3383 Email: Transportation@wi.k12.ny.us

2025 – 2026 School Year

CHILD CARE PROVIDER FORM

Child's Name: _____ School: _____

Address: _____ Telephone: _____

Grade_____ Parents Email:_____
(As of September 2025)

Child Care Provider's Name: _____

Child Care Provider's Address: _____

Child Care Provider's Home & Cell #: _____

I request that my child be transported to/from "Child Care" as follows:

AM Days requested: Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ All ☐
(Please check appropriate box(s))

PM Days requested: Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ All ☐
(Please check appropriate box(s))

Notes:_____

Parent Name:_____
(Please print)

Parent Signature: _____

I, _____, am responsible for providing childcare to
(Child care provider's name, please print)
the above named student(s) on the days and time specified above.

Child cares provider's signature: _____

DO NOT WRITE BELOW THIS LINE. OFFICE USE ONLY._____

Transportation Approval: _____ Date: _____

Bus letter & stop:_____

Bus arrival time: _____