

Precious Cargo Child Transportation Services, LLC

PO Box 52454 · Durham, NC · 27717 · (919) 401-1100 *office*

REGISTRATION FORM

PARENT(S)/LEGAL GUARDIAN(S) CONTACT INFORMATION *(Please Print Clearly)*

Parent/Legal Guardian Name:

Home Address:

Home #

Cell #

Work #

E-mail:

Parent/Legal Guardian Name:

Home Address:

Home #

Cell #

Work #

E-mail:

EMERGENCY CONTACT INFORMATION *(Please Print Clearly)* *In the event of an emergency, when I, the Parent/Legal Guardian cannot be reached, please contact one of the following by telephone. They are authorized to act in my absence, pick up or receive my child/children. (NOTE: Contacts must be someone nearby who can be reached quickly.)*

1st Emergency Contact Name:

Relationship to Child:

Phone #

2nd Emergency Contact Name:

Relationship to Child:

Phone #

Child's Physician's Name:

Phone #

www.preciouscargoshuttle.com

"Finally a way to get kids where they need to be when they need to be there!"

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PASSENGER(S) INFORMATION *(Please Print Clearly)*

1. Child's Name: _____ Gender: _____ Age: _____ DOB: _____

Please indicate any medical conditions or special needs.

Please answer the following:

My Child needs a car seat ___ Yes ___ No

My Child needs a booster seat ___ Yes ___ No

My Child is 12 years of age or older and can sit in the front passenger seat when necessary _____ Yes ___ No

2. Child's Name: _____ Gender: _____ Age: _____ DOB: _____

Please indicate any medical conditions or special needs.

Please answer the following:

My Child needs a car seat ___ Yes ___ No

My Child needs a booster seat ___ Yes ___ No

My Child is 12 years of age or older and can sit in the front passenger seat when necessary _____ Yes ___ No

3. Child's Name: _____ Gender: _____ Age: _____ DOB: _____

Please indicate any medical conditions or special needs.

Please answer the following:

My Child needs a car seat ___ Yes ___ No

My Child needs a booster seat ___ Yes ___ No

My Child is 12 years of age or older and can sit in the front passenger seat when necessary _____ Yes ___ No

4. Child's Name: _____ Gender: _____ Age: _____ DOB: _____

Please indicate any medical conditions or special needs

Please answer the following:

My Child needs a car seat ___ Yes ___ No

My Child needs a booster seat ___ Yes ___ No

My Child is 12 years of age or older and can sit in the front passenger seat when necessary _____ Yes ___ No

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TEXT MESSAGE NOTIFICATION (Optional) Customers have the option to receive drop-off notifications to their cell phones. Customers with children 12 years old and under may also receive pick up notification. Please provide a cell phone number where you can receive these alerts.

(____)____ - _____

TRANSPORTATION SCHEDULE

To School One-Way From School One-Way Round Trip To/From School Service Start Date: _____

Days of Service: (please circle) Monday Tuesday Wednesday Thursday Friday

Desired Pick-Up Time: _____ Desired Drop-Off Time: _____

Pick-Up Location School/Organization Name

Address

Phone

Name of Adult Authorized to Release Child(ren)

Drop-Off Location School/Organization Name

Address

Phone

Name of Adult Authorized to Receive Child(ren)

Alternate Address

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