

“**SAFE, RELIABLE AND PERSONALIZED TRANSPORTATION FOR KIDS AS WELL AS CHILDREN WITH SPECIAL ABILITIES.”**

[www.kidsonwheels.ca](http://www.kidsonwheels.ca) **647-224-2879** info@kidsonwheels.ca

**APPLICATION FOR PRIVATE TRANSPORTATION 2025-2026**

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| --- | --- | --- | --- |
| Child’s first name: | | Child’s last name: | |
| Home Address: | | | Apt#: |
| Postal Code: | City: | Home phone: | |
| Date of Birth: MM/DD/YYYY | Gender: | Child’s Health Card: | |

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| --- | --- | --- |
| Mother’s name: | Work #: | Cell #: |
| Email Address: | | |
| Father’s name: | Work #: | Cell #: |
| Email Address: | | |

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| --- | --- | --- |
| Emergency contact name: | | Relationship to child: |
| Phone #: | Drop-off location: | |

|  |  |
| --- | --- |
| **Morning Pick up**  Address: | **Afternoon Pick up**  Address: |
| Bell Time AM: Supervision begins: | Bell Time PM: Supervision ends: |
| **Morning Drop-off**  Daycare/school/ special program Name:  Address:  Phone#: | **Afternoon Drop-off:**  Daycare/special program/ home Name:  Address:  Phone#: |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Start date: | | End Date: | | | Grade: | |
| Mon: | Tues: | | Wed: | Thurs: | | Fri: |

|  |  |
| --- | --- |
| Does your child have allergies/medical history that we should be aware of or could require immediate treatment? If so, please specify:  Booster seat required: YES / NO  Special needs if any:  Notes/ Comments: | |
| Signature of parent/guardian: | Date: |