

SHUTTLE BUS INFORMATION SHEET

PATIENT NAME:	
SCHOOL:	
GRADE (Fall 2015):	
PARENT CONTACT NAME:	
CELL/PHONE NUMBER:	
PARENT EMAIL:	-
*All information is required in order for patient to be accepted as a shuttle passenger.	? bus
*Fmail will not be distributed for third party use	

77 Southway Ave. Ste. D Lewiston, ID 83501 208.798.4427 Fax: 208.743.4807 www.christensenbraces.com