

## Special Transportation Request Form

Please print or type

Name: \_\_\_\_\_ Student #: \_\_\_\_\_  
Last First M.I. S.S.N. \_\_\_\_-\_\_\_\_-\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Street

\_\_\_\_\_ D.O.B. \_\_\_\_-\_\_\_\_-\_\_\_\_  
City State Zip

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### Parent/ Guardian Information

Parent/ Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Street  
City State Zip

Parent/ Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Street  
City State Zip

### Emergency Contact

Parent/ Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Street  
City State Zip Work Phone: \_\_\_\_\_

### School Information

Home School: \_\_\_\_\_ S/E School: \_\_\_\_\_ Program: \_\_\_\_\_  
Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ Teacher Phone: \_\_\_\_\_

**Medical Information**

Seizures       Diabetic       Hearing Impaired       Visually Impaired       Respiratory Prob.

Non- Verbal       Non- Ambulatory       Other Please Describe:  
\_\_\_\_\_  
\_\_\_\_\_

**Medication Taken:**

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Times Taken: \_\_\_\_\_  
Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Times Taken: \_\_\_\_\_  
Allergies: \_\_\_\_\_

Wheelchair?       Yes       No      Type/ Brand: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Hospital: \_\_\_\_\_

Special Instructions for attending physician:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please review and circle any of the following medical/ health concerns that may apply:

- |                |                      |                           |
|----------------|----------------------|---------------------------|
| Leg Elevations | Brace                | May require snack         |
| Crutches       | Drools               | Elimination Needs         |
| Sling          | Airway Difficulty    | Gastrostomy               |
| Helmet         | Oxygen               | Colostomy                 |
| Cane           | Breathing Assistance | Vasectomy or Ureterostomy |
| Glasses        | Bleeder              | Diaper                    |
| Hearing Aid    | Nothing by mouth     | Harness                   |
|                |                      | Other                     |

Please furnish any special information regarding any of the boxes checked:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Special Behavior Management Needs

Please describe any behavior problems that may occur on the school bus:

---

---

---

---

Please describe any special interventions that may help control these behaviors:

---

---

---

---

Is any special training required for the driver/ aide?

---

---

---

Is a special bus behavior management plan attached?  Yes  No

### Transportation Information

Can child walk to a bus stop?	YES	NO
Can child be dropped off at home, without supervision?	YES	NO
Is an adult bus aide required?	YES	NO

Pick- up address: \_\_\_\_\_ Phone: \_\_\_\_\_

Drop- off address: \_\_\_\_\_ Phone: \_\_\_\_\_

### Office Use Only

School Destination: _____	Program: _____
Teacher: _____	School Starting Date: __/__/____
Attendance Days: Full Day____ A.M.____	M __ T __ W __ Th. __ F __
Half Day____ P.M.____	M __ T __ W __ Th. __ F __
Received at Bus Garage: _____	By: _____
Transportation Started: __/__/____ Bus Numbers:	A.M.____ Noon____ P.M. ____

**Authorization For Transportation Services**

Each of the following persons have participated in the development of these transportation service requirements and by signing below approves them for implementation.

\_\_\_\_\_  
Signature of Parent/ Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/ Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Principal/ Program Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Transportation Dept. Representative

\_\_\_\_\_  
Date

**Authorization For Emergency Medical Treatment**

If I, as a parent/ guardian of the above named student, cannot be contacted in the event of a medical emergency or traumatic injury demanding immediate medical attention, I hereby authorize district staff person or related service provider contracted for by the district to obtain such medical treatment for the above named student.

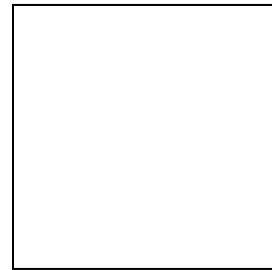
\_\_\_\_\_  
Signature of Parent/ Guardian

\_\_\_\_\_  
Date

If there are any changes in the student's health, medical or behavior status which the parent (s), physical, transportation or other school staff believe may merit changes in staffing, precautions to be taken, interventions, restrains, or any other procedure noted above, the concerned party shall immediately contact the Transportation Department who will in turn initiate the process to evaluate and recommend necessary change with the involvement of parent (s), physician, school, and transportation staff.

This form must be completed before Transportation can begin.  
Parent or guardian is required to notify the bus garage immediately  
Regarding any changes.

Please allow up to five (5) days after receipt of this form by the bus  
Garage for service to begin.



Student Photo