SPECIAL NEEDS TRANSPORTATION FORM

STUDENT INFORMATION: ***Exceptionality*** _____

(TRANSPORTATION USE ONLY)

Student name: _____ Grade: _____ Bus Number/Time: _____

Address: _____ School: _____

Parent/Guardian name: _____ Telephone: _____

Additional Contact Name: _____ Telephone: _____

PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOUR CHILD:

Asthma_____ Blind _____ Diabetes _____ Deaf/Hearing Impaired _____ Heart Disease _____ Hemophilia _____ Respiratory Problems _____

Allergies_____ To What? _____ Actions Needed: _____

Seizures _____ What Type? _____ How Often? _____ Length of Time? _____

What actions should be taken: _____

Does your child take medication? Yes _____ No _____ If so, please list all medications, dosages, and times given below:

_____

_____

Student's Doctor: _____ Phone # _____

Any important information or instructions needed for your child: _____

_____

BUS INFORMATION:

Check all that apply: None _____ Needs assistance boarding bus _____ Preferential seating requested _____ Wheelchair Lift _____

Restraint System Required (SPECIFY) – Guidelines on back of this form

No restraint _____ Lap Belt _____ Five-Point Headstart Seat _____ Safety Vest _____ - Size Needed for Vest (_____)

Parent/Guardian Signature: _____ Case Manager Signature: _____

Bus Driver Signature: _____ Bus Aide Signature: _____

PLEASE NOTE: THE STUDENT WILL BE SUPERVISED AT ALL TIMES AND WILL BE RELEASED TO A RESPONSIBLE PARTY BOTH AT HOME AND AT SCHOOL. THE I.E.P. TEAM MUST DETERMINE ANY EXCEPTIONS.

Persons other than parents who will be allowed to receive the student from the bus: (***ESS- PLEASE INITIAL- FOR APPROVAL***)

1. Name: _____ Age: _____ Approved: Y_____ N_____

   Relationship to Student: _____ Phone #: _____

2. Name: _____ Age: _____ Approved: Y_____ N_____

   Relationship to Student: _____ Phone #: _____

3. Name: _____ Age: _____ Approved: Y_____ N_____

   Relationship to Student: _____ Phone #: _____