SPECIAL TRANSPORTATION REQUEST FORM

PLEASE FAX COMPLETED FORM TO THE TRANSPORTATION OFFICE AT 358-9044

THE TRANSPORTATION DEPARTMENT HAS UP TO 5 SCHOOL BUSINESS DAYS TO ESTABLISH SERVICES

TEACHER COMPLETING FORM ______________________________ DATE _________________ BUS ____________
TRANSPORATION USE ONLY

SPECIAL NEEDS PROGRAM ☐ BSP ☐ CDC ☐ DD ☐ HI ☐ LS ☐ PS ☐ RES ☐ 504/OTHER MEDICAL

OTHER PROGRAM ☐ ELL-ENGLISH LANGUAGE LEARNERS ☐ LPK-LOTTERY PRE K

HOME SCHOOL ______________________________ ATTENDING SCHOOL ____________________________________

DOB _____________ AGE ____ GRADE ____ DISABILITY ____

STUDENT'S NAME ____HOME PHONE __________________________

HOME ADDRESS____

CITY, STATE, ZIP CODE ____

MOTHER'S NAME ____ ALT PHONE ____________________________

FATHER'S NAME ____ALT PHONE ____________________________

PICK UP LOCATION ADDRESS____

DROP OFF LOCATION ADDRESS____

☐ **DROP STUDENT WITHOUT ANYONE PRESENT**

☐ **SOMEONE MUST PHYSICALLY BE AT THE BUS STOP LOCATION (SIDEWALK, MAILBOX, DRIVEWAY, ETC)**

PRIMARY NAME ______________________________________ **ALTERNATE** _______________________________________

☐ BRACES ☐ CARSEAT ☐ HARNESS ☐ SCOOTER ☐ WALKER ☐ WHEELCHAIR

EMERGENCY CONTACTS

NAME/RELATIONSHIP ____ PHONE __________________

NAME/RELATIONSHIP ____ PHONE __________________

MEDICAL CONCERNS

☐ ASTHMA ☐ DIABETES ☐ NONVERBAL ☐ SEIZURES ☐ FEEDING TUBE

☐ HEART CONDITION ☐ HEMOPHILIAC ☐ RESPIRATORY PROBLEMS ☐ VISUALLY IMPAIRED

OTHER MEDICAL CONDITIONS OR ALLERGIES____

____

INSTRUCTIONS FOR MEDICAL CONCERNS____

OTHER BEHAVIORS OR SAFETY CONCERNS ____

____

SUGGESTIONS TO ADDRESS BEHAVIORS____

____

PARENT/GUARDIAN SIGNATURE ____

CMCSS AUTHORIZED SIGNATURE ____