South Washington County Schools Special Transportation Request Form

(School Year 2019-20)

****The information is to be updated annually by the parent/guardian and/or teacher and must be revised if the student's needs, medication, program placement, or assistive equipment use changes during the school year****

Student Name: **Student ID#:**

Reason for Special Transportation Request:

Section 1 check one:

__ RECOMMENDED BY IEP
__ SECTION 504/HEALTH PLAN
(Must attach health plan.)
__ DAY TREATMENT
__ SHUTTLE (ONLY)

Section 2 check all that apply:

__ ADDRESS CHANGE
__ DAYCARE CHANGE
__ EQUIPMENT CHANGE
__ PROGRAM CHANGE
__ NEW STUDENT
__ NEW SCHOOL YEAR
__ RESTART
__ OTHER ___________________________

REQUESTED START DATE	BELL TIMES	PROGRAM NAME/LOCATION	PROGRAM DAYS				
			M	T	W	TH	F
		DOOR:					

SHUTTLE PICKUP LOCATION: ____ **DOOR:**______________________ **TIME:** ________________

SHUTTLE DROPOFF LOCATION: **DOOR:** **TIME:**

STUDENT INFORMATION (Specific) – Completed by Special Services Transportation Rep

STUDENT INFORMATION

Check if any of the following apply: (*If IEP requires additional documentation, please submit with request. Include Behavior and Individual Health Plan if available*)

__AUTISM SPECTRUM DISORDER
__BLIND/VISUAL IMPAIRED
__DEVELOPMENTAL COGNITIVE DELAY
__DEVELOPMENTAL DELAY
__DEAF/HARD OF HEARING
__EMOTIONAL BEHAVIORAL DISORDER
__OTHER___________________________

__ANAPHYLAXIS*
Known Allergies ____
Does the student carry medication to treat these allergies? ☐ YES ☐ NO
__ASTHMA/RESPIRATORY*
__ CARDIAC*
__ DIABETIC*
__SEIZURE DISORDER*

***If no individual health plan is provided, transportation will follow the general health plans provided by the District**

ASSISTIVE EQUIPMENT/SECUREMENT **(All students will be secured in a seatbelt, at minimum)**

__ WHEELCHAIR ☐ MANUAL ☐ ELECTRIC ☐ OVERSIZED **(a BUS AIDE is required for all students in wheelchairs/transport chairs)**

__ TRANSPORT CHAIR **(will student transfer from wheelchair/transport chair to a bus seat YES / NO**)

__ CHILD SEAT (5-point harness) *[**Height = __________Weight = ___________] *Required**

__ INFANT SEAT *[**Height = __________Weight = ___________] *Required**

__ WALKER **(will be secured in wheelchair tiedowns)**
__ OXYGEN TANK **(will need to be secured – either in floor mount or in a wheelchair storage bag or to the leg of the bus seat)**
__ CRUTCHES
__ SAFETY VEST

SPECIAL CONDITIONS BUS AIDE REQUIRED: ☐ Yes ☐ No ☐ NURSE RIDING
(must indicate yes or no)

NOTES FOR THE DRIVER (AND AIDE) ____

____

***(Trans. Rep. Signature)** ____ **EXT.** ____________ **DATE**______________

***(Case Manager/PT Signature)** _______________________________________ **EXT.** ____________ **DATE**______________

To submit form, email spedrouter@sowashco.org

REVISED 4/16/2019

STUDENT INFORMATION (General) – Completed by PARENT/GUARDIAN

STUDENT NAME ____ NICKNAME __________________ SEX(M/F)_____
(Last) (First) MI)

BIRTH DATE _______________ GRADE (as of Sept 2019) ____________ HEIGHT/WEIGHT ____________________

HOME ADDRESS ____
Street Apt/Unit City State Zip Code

PARENT/GUARDIAN NAME ___________________________ ________________________ ____________________
(**primary** contact for transportation) Last First Relationship

(CELL)___________________________ (HOME or WORK)_________________________ ______________________________
Phone #1 Phone #2 Email

PARENT/GUARDIAN NAME ___________________________ ________________________ ____________________
(**secondary** contact for transportation) Last First Relationship

(CELL)___________________________ (HOME or WORK)_________________________ ______________________________
Phone #1 Phone #2 Email

PREFERRED METHOD OF CONTACT ☐ **PHONE** ☐ **EMAIL**

ROUTING INFO – Completed by PARENT/GUARDIAN

PICK-UP LOCATION ☐ HOME ☐ DAYCARE____________________________ ____________________
Name Phone

☐ PARENT TRANSPORT (No Transportation services needed)

DAYCARE ADDRESS____________________________________ ________________________ ______ ____________
Street Apt/Unit City State Zip Code

DROP-OFF LOCATION ☐ HOME ☐ DAYCARE____________________________ ____________________
Name Phone

☐ PARENT TRANSPORT (No Transportation services needed)

DAYCARE ADDRESS____________________________________ ________________________ ______ ____________
Street Apt/Unit City State Zip Code

Student drop off instructions (please check one):

__HAND TO HAND (Adult must receive student at door of vehicle.)

__ EYE TO EYE (Adult must be visible.)

__ RELEASE ON OWN (Driver will not depart from address until student is in the home. Not an option for preschool/early childhood students.)

☐ SELF-GUARDIAN (Next Step use only)

EMERGENCY INFORMATION – Completed by PARENT/GUARDIAN

EMERGENCY CONTACT (OTHER THAN PARENT)____

ADDRESS ____ DAYTIME PHONE # ________________

PHYSICIAN & CLINIC ____ DAYTIME PHONE # ____________________

HOSPITAL (PREFERENCE) ____

I hereby authorize school personnel to contact the physician regarding this transportation request. In case of serious illness or accident, I request the school district to contact me. If they are unable to reach me, I hereby authorize the school district to contact the physician indicated and follow his/her instructions. If it is impossible to contact this physician, the school district may make whatever arrangements are necessary.

It is the parent/guardian responsibility to notify Transportation when transportation is no longer needed.

Signature of Parent/Guardian ____ DATE__________________