Special Transportation Request

Bus Number: ____________

Driver Name: ______________________

Request Date: ______________ Start Date: ____________

Student Name: ____________________________ Grade/Age: ____________ DOB: _________

Requested By: ____

School: ______________________________ Wings/Soar CFT ACE

Special Assistance: None BIP Seatbelt Wheelchair

Booster Seat Safety Vest Waist Size: __________

Other (please explain): ____

____

Parent Contact Information

Guardian: ____________________________ Phone 1: ___________ Phone 2: ___________

Mother Father Other___________

Emergency Name: _______________________ Phone 1: ___________ Phone 2: ___________

AM: PM: Complete Address: ____

AM: PM: Complete Address: ____

Midday: Time: ____________

Guardian: ____________________________ Phone 1: ___________ Phone 2: ___________

Mother Father Other___________

Emergency Name: _______________________ Phone 1: ___________ Phone 2: ___________

AM: PM: Complete Address: ____

AM: PM: Complete Address: ____

Midday: Time: ____________

Medical Information

Does your child take medications: YES NO

If yes, please list all medications, dosages, and time given. ___________________________________

____

Medical Needs/Supports-Describe in detail: ____

____

In the event of a medical emergency, 911 will be utilized, along with notifying the parent.

CONFIDENTIALITY WILL BE STRICTLY MAINTAINED