

STUDENT INFORMATION FOR TRANSPORTATION SERVICES

Student's Name _____

Parent's Name _____

Parent's Home Address ¹ _____

Parent's Home Phone # _____

Father's Work Phone # _____

Date of Birth _____

Mother's Work Phone # _____

Home School _____

Student's Pick-up Address ¹ _____

Student's Delivery Address ¹ _____

Emergency ² Alternate Name _____

Address _____

Phone # _____

Please check appropriate boxes:

Verbal	<input type="checkbox"/>	Non Verbal	<input type="checkbox"/>
Verbal	<input type="checkbox"/>		<input type="checkbox"/>
Ambulatory	<input type="checkbox"/>		<input type="checkbox"/>
Non-Ambulatory		<input type="checkbox"/>	<input type="checkbox"/>
Seizure Disorder		<input type="checkbox"/>	<input type="checkbox"/>
Hemophiliac		<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Disability		<input type="checkbox"/>	<input type="checkbox"/>
Visual Impairment		<input type="checkbox"/>	<input type="checkbox"/>
Hearing Impairment		<input type="checkbox"/>	<input type="checkbox"/>
Diabetic		<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Concerns		<input type="checkbox"/>	<input type="checkbox"/>
Communication Disorder		<input type="checkbox"/>	<input type="checkbox"/>
Other Health Impaired/Medically Fragile		<input type="checkbox"/>	<input type="checkbox"/>
Autism		<input type="checkbox"/>	<input type="checkbox"/>

Please describe any health and/or behavioral concerns that may affect safe transportation of this student:

FOR OFFICE USE ONLY

Bus # _____ AM

Pick-Up Address.- _____

Bus # _____ PM

Pick-Up Address: _____

¹ If apartment, please give apartment complex name, building number, and apartment number.
If rural address, please provide specific directions. If child-care center, please give specific name.

² Emergency alternate address must be in close proximity to child's home.
It is for emergency only and not for routine use.