Submit by Email

SPECIAL NEEDS BUSING REGISTRATION

School use only	
STUDENT ID # REQUIRED	
AUTHORIZED BY:	

Transportation use only		
BUS #		
TIMES:	AM	PM
STARTING DATE:		

STUDENT NAME: _____ **SCHOOL:** _____

PARENT NAME: _____ **GRADE:** _____

_____ **IF PRESCHOOL** ☐ **M / W** ☐ **T /TH**

PHONE NUMBERS: home _____ cell _____ work _____

home _____ cell _____ work _____

ONE PICK-UP LOCATION:

ADDRESS: _____

DROP-OFF LOCATION, IF DIFFERENT FROM PICK-UP

ADDRESS: _____

CONTACT PERSON FOR ABOVE ADRESS _____

CONTACT NUMBER FOR ABOVE ADRESS _____

MEDICAL INFORMATION

WHEELCHAIR ☐ YES ☐ NO **Wheelchair may have to be examined and approved for transportation**

PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT WILL HELP US ARRANGE THE BEST TRANSPORTATION AVAILABLE FOR YOUR CHILD.

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If your student has been diagnosed with any of the following, please contact a school nurse to get a health plan in place. If your student has a life-threatening condition, a health plan must be in place before we can transport your student.

*Asthma *Diabetes *Food Intolerance *Seizure Disorder *Bleeding Disorder *Cardiac Condition *Severe Allergy