Stillwater Area Public Schools Transportation Department

☐ NEW ☐ CHANGE

Confidential Emergency Transportation Information Form

Date:________________ Sch:________________ Program:________________

X-student will ride

Student Name:________________________ Grade:______ D.O.B.____________ ☐AM ☐PM

Home Address:____
(House #) (Street Name) (Apt)

City:____________________ State:______ Zip:________ Home Phone:________________

Parent/Guard Name1:________________ Parent/Guard Name 2:________________

E-mail: ________________________ E-mail:________________________

Day Phone 1:________________________ Day Phone 2:________________________

(Fill out this section only if your student will be transported to/from a place other than home.)

Picked up at: ☐Home ☐Alternate Dropped off at: ☐Home ☐Alternate

Alternate Address Information:

Daycare/Alternate Address:____

City:________________________ State:________ Zip:______________

Daycare/Alternate Contact:________________________ Phone:________________

IEP & Specialized Transportation Information

Please check all boxes that apply, use the back of this form if necessary to accurately list information

Days: M☐ T☐ W☐ H☐ F☐ ____:______drop off at school ______:______pick up at school

Location of P/U & D/O at building:____

School Contact:________________________ Staff Phone:________________

Pupil Transportation Information

- ☐ Ambulatory (walks)
- ☐ Can be transferred to seat
- ☐ Requires Car Seat
- ☐ Ramp lift needed
- ☐ Requires Para/Aide
- ☐ Requires Torso Support/Restraint
- ☐ Uses Wheelchair ☐Manual ☐Electric
- ☐ Walks with Crutches/Walker
- ☐ Wears Leg Braces

Child may leave the bus:

- ☐ on their own. Driver may leave when the child enters the building.
- ☐ only when there is a parent or teacher visible from the door.
- ☐ only when a parent or teacher meets the child at the bus door.

Safety/Health Factors

- ☐ Autistic/ASD
- ☐ Blind/Visually Impaired
- ☐ Diabetic
- ☐ Epilepsy/Seizure Disorder
- ☐ Hyperactive
- ☐ Multiple Disabilities
- ☐ Non-Verbal
- ☐ Oxygen/Respirator
- ☐ Severe Allergies
- ☐ Speech/Lang Impairment
- ☐ Unable to Read/Follow Simple Directions
- ☐ Asthma
- ☐ Deaf/Hearing Impaired
- ☐ Distractible
- ☐ Emotional Behavioral Disorder
- ☐ Impulsive
- ☐ Non-English Speaking
- ☐ Orthopedic Impairment
- ☐ Physically/Health Impaired
- ☐ Self-Destructive Behaviors
- ☐ Traumatic Brain Injury
- ☐ Emergency Plan Attached
- ☐ Other/Not Listed (see reverse)

Doctor's Name:________________________

Hospital/Clinic:________________________ **PH:**____________

Prescription medications the child is taking:________________________

____

Alternate Address/Person where child can be released if parent/guardian is not home:________________________

____

(Please see reverse)

Other Safety/Health Factors Not Listed:
____
____
____
____
____

Signs of Emergency	Steps to Take

My signature below gives permission to share this information with transportation staff & authorizes care be provided to my child as directed in this plan or to call 911 for emergency care. I understand every effort will be made to contact me or the emergency contacts listed.

Signature Parent/Guardian:______________________________

Date:______________________

Please Return This Form to:
Transportation Department
Stillwater Area Public Schools
1875 Greeley Street South
Stillwater, MN 55082

CC: ☐**Student Services** ☐**IEP Manager** ☐**Health Office** ☐**Transportation**