

Tangipahoa Parish School System Special Needs Bus Application & Confidential Medical Information Bus Form

This form is to be completed by the teacher or (school nurse if significant medical needs exist) for students who have special medical concerns or, with justifiable reason(s), cannot be transported on a regular bus. In order to meet the least restrictive environment (LRE) requirement, whenever possible, handicapped students should be transported on a regular bus.

Directions: 1.) Provide all appropriate information requested; attach additional documentation as needed. Please be thorough and complete. 2.) Fax page 1 and 2 (and additional documentation) to 748-2537 for approval and route assignment. 3.) As per Bulletin 1886, present the Bus Driver an approved form with an original photograph of the student. 4.) Retain copies of the approved form for the student's records and the School Nurse. 5.) Changes or updates regarding this form shall be shared immediately by all parties.

This Section: Transportation Department Only	
Bus # _____	Bus Driver _____ Driver's Phone _____
Approved By: _____	Approval Date _____

Today's Date _____	This form is not complete without a current photo of the student!
Students Legal Name _____	
Nick Name _____	
Parent's/Gaurdian's Name _____	
911 Home/Address _____	
Mailing Address _____	
City _____ Zip Code _____	
Home Phone _____ Work Phone _____	
Pager _____ Cell Phone _____	
Daycare Name _____ Phone _____	
Daycare Address _____	
School _____ School Phone _____	
Student's Teacher _____ Teacher's Phone _____	

Directions to Home from School:

Who should be contacted if no one is available at the home or work phone numbers?

Alternate Contact #1 _____ Relationship _____ Phone _____

Alternate Contact #2 _____ Relationship _____ Phone _____

Disability / Diagnosis _____

Non-Catagorical Pre-School? Yes No Date of Birth _____ Present Age _____ Years

Specialized Equipment:

_____ Wheelchair *	_____ Crutches	_____ Eye Glasses
_____ Walker	_____ Ventilator	_____ Communication Device (specify) _____
_____ Braces	_____ Hearing Aid	_____ Other Assistive Device (specify) _____

*Wheelchair must be maintained in a safe condition, have working brakes and a lap belt.

Type Transportation:

_____ Lift Bus (only indicate if student uses the wheelchair lift)	_____ Safety Vest
_____ Bus Attendant	_____ Neck Pad
_____ Parental Reimbursement* _____ No. Miles one-way	_____ Car Seat
<small>*based upon State Department of Education approved rate</small>	
_____ Other (specify) _____	

Special Factors:

Blind / Visually Impaired	Deaf / Hearing Impaired	Communication System
_____ Blind	_____ Deaf	_____ Verbal
_____ Contacts	_____ Hearing Aid Assisted	_____ Non-Verbal
_____ Eye Glasses	_____ Specify Communication Mode:	_____ English
Other _____		Other: _____

Student's Name _____

Special Factors Continued:

Seizure Disorder: Hemophilia Other Impairments
 Petit Mal/Absentia Mild Specify: _____
 Grand Mal/Tonic Clinic Severe _____
 Other: _____ Other: _____ _____

The Bus Driver and Bus Attendant require and have received training regarding the student's special needs.

Yes No Date of Training ____/____/____ Trainer _____ Location _____

Documentation and Action Plan Attached Yes No

If you see this...	Do this...

Behavioral Concerns/Intervention Strategies Appropriate to the Bus:

Allergies (Food, Insect Bite, Medication, etc.)

(Specify): _____

Medications

Medications to be Transported on the Bus: _____

Medications to be Taken at School: _____

Medications Taken at Home: _____

Side Effects of Medication: _____

Special Instructions for Medical Personnel:

Student's Primary Doctor: _____ Doctor's Office Phone: _____

Hospital Preference: North Oaks Hospital Lallie Kemp Hospital Other (Specify): _____

