REQUEST FOR SPECIAL PUPIL TRANSPORTATION SERVICES

*Incomplete/inaccurate forms may be returned to the school and could result in a delay of Transportation services

THINK LEARN BE
MORE
TOGETHER
POCATELLO/CHUBBUCK
SCHOOL DISTRICT 25

DATE: _____

PLEASE INDICATE APPROPRIATE PROGRAM BELOW

- ❑ Crossroads
- ❑ Turning Point
- ❑ Kinport
- ❑ New Horizons
- ❑ Summit Learning Center

- ❑ Special Ed (IEP Driven)
- ❑ Pre-School
- ❑ ESY
- ❑ English as 2nd Language
- ❑ Teen Parent

- ❑ AYP School Choice _____
  (If school choice, list home school above)
- ❑ Overload _____
  (If Overload, list home school above)
- School student will be attending_____

❑ Teacher_____
(List teacher for Special Ed & Pre-School only)

❑ Other_____
(Please specify program if not listed above)

❑ Initial Request ❑ Terminate ❑ Annual Review (IEP Driven) ❑ Change 1st 2nd 3rd	**REQUESTED START DATE** _____ *Allow 3 days for implementation after submitted to Transportation Department	**IEP TEAM** YES NO **RELATED SERVICE REQUEST** ❑ ❑ Special Transportation must be approved by the Director of Special Services (signature required below)

STUDENT INFORMATION

Student Name: _____ Age: _____ Grade: _____

* NO P.O. BOX NUMBERS OR RURAL ROUTES NUMBERS – GIVE NAME OF ROAD HOME FACES *

Home Address Street: _____ City: _____ ZIP: _____

Rural Areas Only

Name of road home faces: _____ between road: _____ and road _____

General description (i.e. markings on home, fence, mailbox, landscaping, etc.): _____

_____

PARENT / GUARDIAN INFORMATION

Parent / Guardian Name: _____ Relationship to student: _____

Contact #'s: (Home) _____ (Cell) _____ (Work) _____

Emergency Contact Person's Name: _____ Relationship to student: _____

Emergency Contact Person's Address: (street) _____ City: _____ ZIP: _____

Emergency Contact #'s: (Home) _____ (Cell) _____ (Work) _____

TRANSPORTATION DEPARTMENT USE ONLY

Date received by Transportation Department: _____

A.M. Pickup Point: _____ Time: _____ Route #: _____

A.M. Transfer Point: _____ Time: _____ Route #: _____

Mid-Day Pickup Point: _____ Time: _____ Route #: _____

Mid-Day Drop Off Point: _____ Time: _____ Route #: _____

P.M. Transfer Point: _____ Time: _____ Route #: _____

P.M. Drop Off Point: _____ Time: _____ Route #: _____

SIGNATURES:

PARENT SIGNATURE (REQUIRED) _____

DIRECTOR OF SPECIAL SERVICES: _____

Special Transportation must be approved by the Director of Special Services

Pocatello/Chubbuck School District #25
Transportation Department
Fax: (208) 235-3241
Dispatch: (208) 235-3227
Regular Routes: (208) 235-3215
Special Needs Routes: (208) 235-3252

FORM 730 REVISED 07/22/13

SPECIAL CONCERNS OR CONSIDERATIONS

Health Concerns –

Please list any health or medical concerns you feel the Transportation Department should be aware of

(i.e. vision impairments, hearing impairments, seizures, frequent bloody noses, etc.): _____

_____

_____

_____

Behavioral Concerns –

Please list any behavioral concerns you feel the Transportation Department should be aware of

(i.e. occurrences of vandalism, violent tendencies, infatuation with weapons, infatuation with fire/arson, etc.): _____

_____

_____

_____

Other Concerns –

Please list any other concerns or comments you feel the Transportation Department should be aware of

(i.e. is this student a transition student, will student be catching any shuttle bussing, etc.): _____

_____

_____

_____

Special Equipment or Scheduling Considerations: *(please check all that apply)*

- ○   Car Seat(s) Required
- ○   Harness Required
- ○   Wheelchair Lift Required
- ○   Oxygen Bottle

- ○   Teen Parent with infant(s) or toddler(s)
- ○   Sibling(s) riding with student
- ○   Other *(please specify)*: _____

_____

Special pick up or drop off point if different from home address: <mark>*NOTE – Only one pick up and drop off can be established per student*</mark>

Pick up point: Name: _____

                Address: _____

                Phone #: (home)_____ (cell)_____ (work) _____

Drop off point: Name: _____

                Address: _____

                Phone #: (home)_____ (cell)_____ (work) _____

Drop off procedure: <mark>*NOTE – This section is required to be completed for IEP driven requests only*</mark>
         (CHECK ONLY ONE BOX)

- ☐   **Assisted drop off –** The driver will not let the student off the bus unless a family member is at the bus to take the student off of the bus.

- ☐   **Visual proof of family member –** The driver will not let the student off the bus unless the driver has visual proof that a family member is home and at the door ready to accept the student.

- ☐   **Visual proof of the student entering the home –** The driver will not leave the drop off point until he/she has obtained visual proof of the student entering the home.

- ☐   **Un-assisted drop off -** The driver will drop the student off at their household or designated stop and allow the student to walk to and enter the home on their own.

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