

Roseville Area School's Transportation Request for Fairview PreK Programs

Action Type: Add Change Cancel

Effective Date:

Does the student have an IEP? Yes No

Learner's Name:	Grade:	Birth Date:	Telephone:	Date:	Requested by:
Learner's Home Address:					Resident District #:
Transportation Address (if different from home):					P/U Phone:
Pickup Address Information: Street Address:			City:		

Drop Off Address Information:		D/O Phone:
Street Address: City:		
School:	Program Days: <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> All	Approved by:
School Address:	Program Contact Person:	District:
School Start and End Times for Student: From: to:	Phone Number: Fax:	
(Naomi Banick - use School Readiness Calendar) <input type="checkbox"/> School Readiness	(Jolene Moore - use ECSE Calendar) <input type="checkbox"/> ECSE Early Literacy <input type="checkbox"/> ECSE CID <input type="checkbox"/> ECSE <input type="checkbox"/> ECSE Individual <input type="checkbox"/> ECSE Side x Side <input type="checkbox"/> ECSE SR <input type="checkbox"/> ECSE Phonology	

Comments:

Primary Disability	Assistive Equipment	Special Condition
<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Electric Wheelchair	<input type="checkbox"/> Custodial Transfer
<input type="checkbox"/> Blind/Visual Impairment	<input type="checkbox"/> Manual Wheelchair	<input type="checkbox"/> Bus Aide
<input type="checkbox"/> Deaf/Blind	<input type="checkbox"/> Needs Lift Bus	<input type="checkbox"/> Door-to-Door Pickup/Drop
<input type="checkbox"/> Deaf/Hard of Hearing	<input type="checkbox"/> Seatbelt	<input type="checkbox"/> One to One Bus Aide
<input type="checkbox"/> Developmental Cog. :MMI	<input type="checkbox"/> Uses a Walker	<input type="checkbox"/> Can be left alone
<input type="checkbox"/> Developmental Cog. :MSMI	<input type="checkbox"/> Crutches/Cane	<input type="checkbox"/> Other
<input type="checkbox"/> Developmental Delay/ECSE	<input type="checkbox"/> Torso Restrainer	
<input type="checkbox"/> Emotional/Behavioral Disorder	<input type="checkbox"/> Booster Seat	
<input type="checkbox"/> Other Health Impaired	<input type="checkbox"/> Car Seat	
<input type="checkbox"/> Physically Impaired	<input type="checkbox"/> Oxygen/Ventilator	
<input type="checkbox"/> Severely Multiply Impaired		
<input type="checkbox"/> Specific Learning Disability		
<input type="checkbox"/> Speech/Language Impaired		

Emergency Information (If Available)		
Parent's Name:	Mother Work Phone:	Father Work Phone:
Emergency Contact (other than parent):	Home Phone:	Work Phone:
Relationship to Student:		
Name of Neighbor with whom Student can be left:		
Neighbor Address:	Phone:	
Physician/Clinic:	Phone:	
Hospital (preference):		