

**SPECIAL NEEDS TRANSPORTATION REFERRAL
STUDENT INFORMATION**

STUDENT NAME: _____ DOB: _____

SCHOOL: _____ DISABILITY AREA(S): _____

PARENT(S) NAME: _____

ADDRESS: _____

_____ PHONE: _____

STUDENT IS: _____ VERBAL _____ NON-VERBAL

_____ AMBULATORY _____ NON-AMBULATORY

SPECIFIC MEDICAL AND/OR BEHAVIORAL CONSIDERATIONS: _____

ACCOMMODATIONS/MODIFICATIONS NEEDED:

_____ BUS ASSISTANCE: _____ ADULT SUPPORT _____ MEDICAL SUPPORT

_____ PREFERENTIAL SEATING

_____ BEHAVIORAL INTERVENTION PLAN

_____ WHEELCHAIR LIFT AND SECUREMENT SYSTEM

_____ TRANSPORTED IN W/C _____ TRANSFERRED TO BUS SEAT

_____ RESTRAINT SYSTEM (SPECIFY) _____

_____ OTHER (PLEASE EXPLAIN) _____

REFERRED BY: _____ POSITION: _____

RECEIVED BY: _____ DATE: _____

*INFORMATION SHARED WITH BUS DRIVER AND ATTENDANT:

BUS DRIVER SIGNATURE

DATE

BUS ATTENDANT SIGNATURE

DATE

*****CONFIDENTIALITY WILL BE STRICTLY MAINTAINED.**