

ST. MARY'S COUNTY PUBLIC SCHOOLS
REQUEST FOR TRANSPORTATION ON A SPECIAL NEEDS BUS

SCHOOL YEAR: 2024-2025

The student will attend the following school and session:

- FULL DAY SCHOOL: _____
- ½ DAY A.M. SCHOOL: _____
- ½ DAY P.M. SCHOOL: _____

SESSION DAYS

- (Check all that apply) Monday
 Tuesday
 Wednesday
 Thursday
 Friday

****ON EARLY DISMISSAL DAYS, THERE WILL BE NO TRANSPORTATION PROVIDED FOR STUDENTS ON A MODIFIED TIME SCHEDULE**

THIS SECTION FOR DEPARTMENT OF TRANSPORTATION ONLY

- Trip 1: Bus # _____ TO _____
- Trip 2: Bus # _____ TO _____
- Trip 3: Bus # _____ TO _____
- Trip 4: Bus # _____ TO _____
- APPROVED Bus Stop Location:**
- Pick Up _____
- Drop off _____

DATE OF TRANSPORTATION TO BEGIN: _____ (Enter specific date and must be minimum of seven school days)

SPECIAL NEEDS BUS CANCELLED ON: _____ REASON: _____

STUDENT INFORMATION:

CONTACT INFORMATION:

- First Name _____ Parent/Guardian Name _____
- Last Name _____ Home Phone Number _____
- Student 6 – Digit I.D. Number: _____ D.O.B.: _____ Cell Phone Number _____
- Age: _____ Approx. Weight: _____ Home School: _____ Emergency Contact # _____
- Student Pick-Up Address: _____ Student Drop-Off Address: _____

- IEP PST Date Special Transportation recommended: _____ BUS ATTENDANT NEEDED? YES NO
- Disabling Condition: (I.e. ADHD, HEARING IMPAIRED, ETC.) _____ MAY STUDENT BE DROPPED OFF UNATTENDED? YES NO
- _____ IF NO, WHO WILL MEET THE BUS? _____
- If Seizures, what action is required? _____ BUS STOP TYPE: REGULAR SPECIAL NEEDS
- _____ IS STUDENT CAPABLE OF WALKING TO CORNER/ INTERSECTION? YES NO
- What Medications if any? _____ IF NO, WHY? _____

Driver must be aware of all medication and it must be secured away from the student

PROGRAM INFORMATION

STUDENT APPARATUS NEEDS

SPECIAL INSTRUCTIONS FOR DRIVER TO MAKE STUDENT MORE COMFORTABLE? _____

- Classroom Instruction/Regular Education
 COMPASS
 Gateway Program
 Infant and Toddler Program
 Learning Adjustment Program (LAP)
 Pre-school Special Education
 SAIL
 TIDES

- NONE
SAFETY RESTRAINT OPTIONS:
 Seatbelt
 - 5 point seatbelt 20-90 lbs
 - 3 point seatbelt if available
 Safety Vest
 Other _____
 Oxygen
 Walker
 Wheelchair
 - Electric? Yes No

- 504
 Other _____

IEP/PST Chairperson _____ Date _____

Director of Special Education _____ Date _____

Director of Transportation _____ Date _____

FORM DIRECTIONS:

- Fill out form completely
- Submit original to Dept. of Special Education
- Incomplete forms will be returned to IEP/PST Chairperson