

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

**SCHOOL YEAR: 2026-2027**

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?  
 \_\_\_\_\_ IF NO, WHY? \_\_\_\_\_  
 What Medications if any? \_\_\_\_\_

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

**PROGRAM INFORMATION**

- Classroom Instruction/Regular Education  
 COMPASS  
 Gateway Program  
 Infant and Toddler Program  
 Learning Adjustment Program (LAP)  
 Pre-school Special Education  
 SAIL  
 TIDES  
 HIGH ROAD  
 504  
 Other \_\_\_\_\_

**STUDENT APPARATUS NEEDS**

- Oxygen  
 Walker  
 Wheelchair  
 - Electric?  Yes  No

**IEP TEAM DETERMINATION**

- NONE  
**SAFETY RESTRAINT OPTIONS:**  
 Seatbelt  
 - 5 point seatbelt 20-90 lbs  
 - 3 point seatbelt if available  
 Safety Vest  
 Seat Belt Buckle Cover  
 Other \_\_\_\_\_

**SPECIAL INSTRUCTIONS FOR DRIVER TO MAKE STUDENT MORE COMFORTABLE?**

**FORM DIRECTIONS:**

- Fill out the form completely.
- For Special Education Students only: Submit original to Dept. Of Special Education
- Transportation will be assigned after the signed form is received in the Department of Transportation and may take up to seven professional days.

IEP/PST Chairperson \_\_\_\_\_ Date \_\_\_\_\_  
 Director of Special Education \_\_\_\_\_ Date \_\_\_\_\_  
 Director of Transportation \_\_\_\_\_ Date \_\_\_\_\_