



SPECIAL EDUCATION TRANSPORTATION FORM (F-12)

STUDENT INFORMATION

Student Name: _____ SID#: _____ Grade: _____
 (Last Name, First Name)

Home Address: _____ Zip: _____ Home Phone: _____
 _____ Cell Phone: _____

 Current Sch of Attendance _____

SERVICE INFORMATION

Request Action: _____ Service Type: _____

Transport to which school: _____ Effective Date: _____ (allow 2 weeks for set up)

Days/Times for this service request: M T W Th F AM PM All Day STARS

Pick Up Address: _____
 Street # _____ Frac _____ Dir _____ Street Name _____ Apt. # _____

Drop Off Address: _____
 Street # _____ Frac _____ Dir _____ Street Name _____ Apt. # _____

Level of Service

- LOS 2 = Corner Stop Service LOS 4 = Arterial Bus Stop
 LOS 3 = Neighborhood Bus Stop LOS 9 = Curbside Service

Disability:

NOTE: If transportation is being considered for a student outside the regular school bus levels of service (District Procedure 5415 4.d.), a Transportation Representative must be present at the IEP meeting.

Services Required:	Equipment Required:
<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> A – Monitor Required	<input type="checkbox"/> B – Lap Belt Required
<input type="checkbox"/> N – Nurse Required	<input type="checkbox"/> BC – Lap Belt Buckle Cover
<input type="checkbox"/> Wheelchair Accessible Bus	<input type="checkbox"/> C – Car Seat
	<input type="checkbox"/> H – Small Safety Vest w/Crotch Strap
	<input type="checkbox"/> H – Medium Safety Vest
	<input type="checkbox"/> H – Large Safety Vest
	<input type="checkbox"/> O – Oversized/Powered Wheelchair
	<input type="checkbox"/> R – D-Ring Required
	<input type="checkbox"/> K - Walker
	<input type="checkbox"/> W – Wheelchair

If student Must Be Met (MBM), we need to know 'by whom', the name and tel # are required.

STUDENT MUST BE MET? YES NO By whom: _____
 Name _____ Tel # _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship: _____ Tel#: _____

CASE MANAGER INFORMATION

Case Manager Name: _____ Email: _____

CM Comments: _____ (Required)

(Reason for this request, specific changes, etc.) _____ CM Tel#: _____

Date Sent to Special Ed: _____

Attach copies of Page 1 of the IEP, Transportation page, and Team Action Page from current IEP.

*IEP must be locked. (not needed for Drops)

Fax/Email completed form and IEP documents to (619) 725-7246.

SPECIAL ED DEPT.
Approved: YES NO
Date: _____