TBA ISD LEADING LIFETIME LEARNING

Traverse Bay Area Intermediate School District
1101 Red Drive, P.O. Box 6020
Traverse City, MI 49696-6020
(231) 922-6200 FAX: (231) 922-7821

Transportation Request

This form must be completed BEFORE transportation can begin. Parent or guardian is required to notify the local transportation department immediately regarding any changes. **Please allow up to ten (10) days after receipt of this form by the local transportation department for service to start.**

Student:_____ UIC:_____ Date:_____

Address: _____

City, State, Zip:_____ Home Phone:_____ DOB:_____

Parent Name:_____ Disability Label: _____

Attending School:_____ Resident School District:_____

Program:_____ Director of Program:_____ Phone:_____

*Pick-up Address:_____ Zip:_____ Phone:_____

*Drop-off Address:_____ Zip: _____ Phone:_____

*Must be a SINGLE pick-up/drop-off address. Multiple addresses will be parent/guardian responsibility.

Attendance Days: Full Days M T W TH F ALL

Half Days M T W TH F AM PM

Emergency Contacts:

Name:_____ Relationship:_____

Phone:_____(home) _____(work) _____(cell)

Address: _____ City, State, Zip:_____.

Name:_____ Relationship:_____

Phone:_____(home) _____(work) _____(cell)

Address: _____ City, State, Zip:_____.

Current Medications:

Medication:_____ Dosage:_____ x_____

Medication:_____ Dosage:_____ x_____

Medication:_____ Dosage:_____ x_____

Allergies:_____

Seizure Plan: ___Yes ___No

Family Physician:_____ Phone:_____

Distribution: White-Transportation Supervisor Yellow-Attach to IEP

Student:_____ UIC:_____ Date:_____

Is student physically able to walk to an established bus stop? ___Yes ___No
If no, please explain_____

Can student be transported on a regular education bus? ___Yes ___No
If no, please explain_____

Can student be released without supervision? ___Yes ___No
If no, please explain_____

Does the student require a wheelchair? ___Yes ___No
If yes, wheelchair must be approved and properly maintained. Owner of wheelchair_____

Is a bus assistant required? _____ IEP:_____ ___Yes ___No

If yes, please explain_____

___Behavior ___Medical ___Bus Assistant available on bus?

Please check the following that apply:

___Airway Difficulty
___Bleeder
___Breathing Assistance
___Diabetes
___Elimination Disorders
___Hearing Impairment
___Non-Verbal
___Oxygen
___Respiratory Problem
___Seizure Problems
___Visual Impairments

Please check the following that concern you:

___Abusive toward themselves
___Difficulty understanding directions
___Physically assaultive
___Verbally assaultive
___Insubordinate

Comments and Insights: (If any of the above apply, how severe is the concern?)

_____

_____

Other Recommendations:

_____

_____

Strategies that work at school:

___Assigned seating
___Divert attention
___Non-verbal cues
___Praise for better behavior
___Use of humor
___Verbal cues
___Behavior Plan Developed

Explain: (Behaviors we expect to see related to the child's disability)

_____

_____

Authorization for Emergency Medical Treatment

If I, as the parent/guardian of the above named student, cannot be contacted in the event of a medical emergency or traumatic injury demanding immediate medical attention, I hereby authorize any district staff person or related service provider contracted by the district to obtain such medical care and treatment for the student.

Parent/Guardian Signature:_____ Date:_____

Administrator Receiving Request:_____ Date:_____

Distribution: White-Transportation Supervisor Yellow-Attach to IEP