# MORGAN COUNTY SCHOOLS

## SPECIAL EDUCATION TRANSPORTATION FORM

DP 1.3C-7

SPECIALIST: _____ DATE SUBMITTED _____

STUDENT: _____ MEDICAID# _____

Age: _____ Date of Birth: _____ Home School: _____

Parent/Guardian Name: _____

Home Mailing Address: _____

Directions to Home: _____

_____

_____

Home Telephone: _____ Work Telephone: _____ Cell Number: _____

Contact Person (other than above) in Case of Emergency:

Name: _____ Telephone: _____

**INDIVIDUAL EDUCATION PROGRAM TRANSPORTATION REQUIREMENT**

Special Devices/Equipment: _____

Special Care: _____

Medical Considerations: _____

Extended Time in Transit: _____

- Medication: If yes, County-adopted Medication Form must be attached with indication from physician for time/dosage. (or letter from doctor saying same)

Physician to Contact in Case of Emergency: _____

Telephone: _____ Location: _____

Parent/Designee at Bus Stop: A.M. _____

P.M. _____

Aide Required: Yes ☐ No ☐ Weight: _____ Height: _____ Waist: _____

**(FOR STUDENTS REQUIRING FEDERALLY APPROVED SAFETY DEVICE)**

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PROGRAM SCHOOL: _____ PROGRAM AREA: _____

PRESCHOOL SPECIAL NEEDS: (Please check one) A.M. ☐ P.M. ☐

BUS STOP LOCATION: _____

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Transportation Information Completed By: _____

Date: _____