Application for
Temporary Special Transportation
For a Pupil Attending Regular School Classes

Do not use for students attending approved special education classes

Today's Date: _____

STUDENT INFORMATION

Name _____ Birthdate _____

Address _____ Phone _____

Parent or Guardian _____ Phone _____

School _____ Grade _____ School year _____

PHYSICIAN'S CERTIFICATE *This section must be completed by examining physician*

Nature of injury, or diagnosis _____

In my opinion this student requires special transportation ❍ Yes ❍ No for how long _____

Reason transportation is required _____

Assistive equipment required (wheelchair, crutches, etc) _____

Examining Physician Signature _____ Date _____

Print or type name _____ Phone number _____

Examination and form must be completed for current school year. Rubber stamp signatures not accepted.

SCHOOL'S RECOMMENDATION

Recommend special transportation? ❍ Yes ❍ No Dates to _____ From _____

Needs pickup ❍ at house ❍ at a closer corner ❍ with lift bus ❍ Other

School Principal Signature _____ Date _____

FOR TRANSPORTATION OFFICE USE ONLY

Route # _____ Pickup time _____ Take home time _____

Stop location _____ Effective date _____