



REQUEST FOR SPECIAL NEEDS TRANSPORTATION
 (Special Needs transportation defined as van or wheelchair vehicle service)

Date:		New Request:		Yes		No
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Duration	Start Date:		Finish Date:	
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GENERAL INFORMATION

Name of Student:			
School Attending:		Student Number:	
Home School:		Grade:	
Student's Birth Date (MM/DD/Year):			
Transportation Address	Civic/House/Apt/Unit No./Street Name:		
	City/Town/Municipality:	Postal Code:	
Name of Parent/Guardian:		Home Phone:	
		Work Phone:	
		Cell Phone:	

IPRC	Communication	Intellectual	Physical
	<input type="checkbox"/> Speech Impairment <input type="checkbox"/> Learning Disability <input type="checkbox"/> Language Impairment <input type="checkbox"/> Autism <input type="checkbox"/> Deaf/Hard of Hearing <input type="checkbox"/> Behaviour <input type="checkbox"/> Multiple Exceptionality: _____	<input type="checkbox"/> Developmental Disability <input type="checkbox"/> Mild Intellectual Disability <input type="checkbox"/> Giftedness <input type="checkbox"/> Other	<input type="checkbox"/> Vision Impairment <input type="checkbox"/> Other Physical <input type="checkbox"/> Wheelchair

Review Date:

REASON FOR SPECIAL TRANSPORTATION NEEDS

1.) Special Class Placement (50% or more time spent in Spec. Ed.)		
UCDSB SDC Programs:	CDSBEO/UCDSB Out of Board	CDSBEO Programs
<input type="checkbox"/> Early Intervention <input type="checkbox"/> Development <input type="checkbox"/> DEPP <input type="checkbox"/> Multi Needs	<input type="checkbox"/> CHEO <input type="checkbox"/> ROH <input type="checkbox"/> McHugh <input type="checkbox"/> Section 23	<input type="checkbox"/> Turning Points <input type="checkbox"/> ABLE
Program Location (Name and Address)		
Name of Program/Site: _____		
Contact Name: _____		
Address: _____		
Phone Number: _____		
2.) Other Special Needs of the Student		

LIFE THREATENING EMERGENCY FORMS

Are "Life Threatening Emergency Medical" form(s) required for this child and if so please ensure that a copy is forwarded to STEO, the Bus Contractor and the Bus Driver.	<input type="checkbox"/> Yes <input type="checkbox"/> Not Required
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TRANSPORTATION REQUIREMENTS

Child is capable/able to ride a regular yellow bus Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Own Seat <input type="checkbox"/> Special Equipment <input type="checkbox"/> Booster Seat
If 8 years of age and under: Student Weight (kg): _____ Student Height (cm): _____
Special Instructions/Comments:
State all conditions/limitations of the student:
List any additional equipment that is required to transport the student:
Program schedule (i.e. Regular Day, A.M./P.M. only, Early Dismissal):
School arrival and departure times for this student (<i>flexibility in arrival/departure times may be required</i>):

Parent(s)/Guardian(s): I/we authorize that this "Request for Special Transportation" form can be forwarded on to the bus contactor/driver by STEO for the purpose of setting up transportation.	
Parent(s)/Guardians(s) Signature:	Date:

School Principal/Spec Ed Department or Designate:

Please ensure that you completely fill in this form or it will be returned to you thereby delaying transportation set-up. Special transportation may take up to **five (5) working days to organize.**

Authorized Signature:	Effective Date:
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Yes	<input type="checkbox"/>	Hard copy of this form signed by the parent(s)/guardian(s) and the school principal or designate has been forwarded to the Special Education Department.
No	<input type="checkbox"/>	

Special Education Department:

Authorized Signature:	Effective Date:
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STEO DEPARTMENT ONLY:

Transportation Start Date:	
Bus Operator:	
Route Number:	