

ALBUQUERQUE PUBLIC SCHOOLS STUDENT TRANSPORTATION FORM

ESY Student Transportation Services

SCHOOL YEAR 2009-2010

Bus # _____ Start Time _____ Dismissal Time _____

Program Type _____ Day of Attendance M Tu W Th F

Date _____ Assigned Destination _____ Track _____ Grade _____ Level _____ Home School _____ Previously Assigned School _____

Student First Name _____ Last Name _____ Date of Birth _____ Student # _____

Home Address _____ Type _____ Zip Code _____ Home Phone _____

Pick-Up Location (Before School) _____ Phone # _____

Name of Caretaker at Pick-up Location (if different from Parent) _____

Drop-Off Location (After School) _____ Phone # _____

Name of Caretaker at Drop-off Location (if different from Parent) _____

Mother or Guardian _____ Work Phone # _____

Father or Guardian _____ Work Phone # _____

TWO DIFFERENT LOCAL ALTERNATE CONTACTS: (Must be Provided)

Name _____ Address _____ Phone # _____

Name _____ Address _____ Phone # _____

Emergency Medical Information: Doctor _____ Hospital Preference _____

911 WILL BE CALLED IN CASE OF AN EMERGENCY. Special Instructions for Attending Physician or Emergency Personnel:

Student CANNOT be Left Unattended Due to Health And or Saftey Reason _____

NEARBY LOCATION, NAME AND PHONE NUMBER WHERE STUDENT MAY BE DELIVERED IF NO ONE IS AT DROP OFF LOCATION AND STUDENT CANNOT BE LEFT ALONE

Nearby Drop Off Location _____ Phone # _____

Student CAN be Left Unattended Parent or Guardian Signature Acquired?
Parent Primary Language _____

*** MUST BE COMPLETED BY PROGRAM SUPPORT SPECIALIST / DESIGNEE**

Check: <input type="checkbox"/> Nonverbal	<input type="checkbox"/> Nonambulatory	<input type="checkbox"/> TBI	<input type="checkbox"/> Seizure Disordered	<input type="checkbox"/> MD	<input type="checkbox"/> Other
<input type="checkbox"/> Health Impaired	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Visually Impaired	<input type="checkbox"/> Diabetic	<input type="checkbox"/> ED	
<input type="checkbox"/> Mentally Retarded	<input type="checkbox"/> Learning Disabled	<input type="checkbox"/> Developmentally Delayed	<input type="checkbox"/> Behavior Concerns	<input type="checkbox"/> Autistic	

Additional information driver/attendant should be aware of regarding above checked items and/or other particular conditions

Primary Language _____ Assistive Device _____

Current Medications & Dosages _____

Allergies N/A

Does student require wheelchair lift? Yes No
Type of Wheelchair _____

Contact Cluster Facilitator (If checked, contact person listed below for additional information prior to transporting the student)

Cluster Facilitator _____ Cluster Facilitator Phone _____

Desired Start Date _____

Program Support Specialist Designee Name _____ Email _____ Contact Number _____

Transportation Office Use Only Contractor _____ STS _____ Date Assigned _____

All buses utilizing a wheelchair lift will have a bus attendant. Documentation supporting special transportation can be found in the student's current IEP.
SERVICE BEGINS 3-5 SCHOOL DAYS AFTER RECEIPT OF THE ORIGINAL COMPLETED FORM AT STUDENT TRANSPORTATION SERVICES.
This information is to be maintained in accordance with Family Educational Rights and Privacy Act.