Baldwinsville Central School District
TRANSPORTATION DEPT.
29 East Oneida Street
Baldwinsville, N.Y. 13027
315-638-6097 Office 315-638-6141 Fax

REQUEST FOR SPECIAL TRANSPORTATION SERVICES

This form is to be completed by the parent or guardian and the attending physician of a student who may need special transportation due to a physical injury that impedes the student's ability to embark and disembark from their regular assigned bus.

PARENT/GUARDIAN COMPLETE THIS SECTION:

Name of Student: ______________________________

Home Address: ______________________________

Phone #: ______________________________

Address Pick-up & Drop Off: ______________________________

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Name, Address & Phone Number of Pick-up and Drop-Off Location (If different than home address.)

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PHYSICIAN COMPLETE THIS SECTION

Patient's Name: ______________________________

Reason for special Transportation Services: **(Must be able to clear 14" bus step otherwise WC)**

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Anticipated Length of time for the Special Transportation: ______________________________

Physician's Signature: ______________________________

Date: ______________________________ Phone # ______________________________

BUILDING PRINCIPAL

Name of School: ______________________________

****After discussing the information with the parents and the school nurse this request is to be sent to the Transportation Department.****

Signature of Principal: ______________________________

Date: ______________________________

(Transportation may take up to three school days to accommodate.)

3/6/06