

SCOTCH PLAINS-FANWOOD PUBLIC SCHOOLS
SCOTCH PLAINS, NEW JERSEY

REQUEST FOR SPECIAL TRANSPORTATION

SECTION I: To be completed by parent

Name of Student _____ Name of Parent _____

Home Address _____ Home Telephone _____

School _____ Grade _____

I request special transportation for my son/daughter due to the physical disability described.

Special transportation will end on the date indicated in Section II. Extension will require completion of another Request for Special Transportation.

(signature of parent)

(date)

SECTION II: To be completed by attending physician

Nature of physical disability _____

Special transportation will be required from _____ to _____
(date) (date)

(signature of physician)

(date)

(name of physician - please type, print, or stamp)

RETURN REQUEST TO SCHOOL NURSE WHEN SECTIONS I AND II ARE COMPLETED.

SECTION III: To be completed by district staff

Date completed request returned to nurse _____

Approved by nurse _____
(signature of nurse) (date)

Approved by Medical Inspector _____
(signature of Medical Inspector) (date)

Approved by Director of Special Services _____
(signature of Director) (date)

SECTION IV: To be completed by Coordinator of Transportation

Date transportation to start _____

Anticipated date transportation to terminate _____

Date transportation terminated _____