

**ST. CLAIR CATHOLIC DISTRICT SCHOOL BOARD**

**SPECIAL EDUCATION TRANSPORTATION REQUEST**

**PART A (TO BE COMPLETED BY THE SCHOOL)**

School: \_\_\_\_\_

Student Name: \_\_\_\_\_ Student Number: \_\_\_\_\_

Home Number: \_\_\_\_\_ Grade: \_\_\_\_\_ Age: \_\_\_\_\_

911 Address: \_\_\_\_\_ (street)  
\_\_\_\_\_ (city)

Parents/Guardian Names:

\_\_\_\_\_ (father) \_\_\_\_\_ (work number)

\_\_\_\_\_ (mother) \_\_\_\_\_ (work number)

Emergency Contact Number: \_\_\_\_\_

Name of Emergency Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Pick Up (Location): \_\_\_\_\_ Program Start Time: \_\_\_\_\_

Drop Off (Location): \_\_\_\_\_

Return Trip Required: Yes No

Program End Time: \_\_\_\_\_

Drop Off (Location): \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

NOTES OF SPECIFIC NEEDS:

\_\_\_\_\_  
Principal's Signature

\_\_\_\_\_  
Date

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**PART B (TO BE COMPLETED BY THE SPECIAL EDUCATION CONSULTANT)**

Transportation:        Approved    \_\_\_\_\_  
   Not Approved \_\_\_\_\_

NOTES:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**PART C (TO BE COMPLETED BY TRANSPORTATION DEPARTMENT)**

Pick Up Time: \_\_\_\_\_

Location: \_\_\_\_\_

Drop Off Time: \_\_\_\_\_

Location: \_\_\_\_\_

Operator: \_\_\_\_\_

Operator Phone Number: \_\_\_\_\_

Route Number: \_\_\_\_\_

NOTES:

\_\_\_\_\_  
Route Technician

\_\_\_\_\_  
Date

*Distribution:        Special Education Consultant  
   School Principal  
   Transportation Department*