

Bus # _____
Bus Stop: _____
AM: _____
PM: _____

FAMILIES IN TRANSITION AND FOSTERING CONNECTIONS
SPECIAL TRANSPORTATION REQUEST FORM
Please Email completed form to FIT Office
Complete One Form Per School

OFFICE USE ONLY
DATE RECEIVED _____
DATE SUBMITTED _____

REQUEST DATE: _____

PERSON COMPLETING FORM/ RELATIONSHIP TO STUDENT: _____

BEGIN SPECIAL TRANSPORTATION CHANGE SPECIAL TRANSPORTATION
REASON TRANSPORTED: FAMILIES IN TRANSITION FOSTERING CONNECTIONS

ZONED SCHOOL: _____ ATTENDING SCHOOL: _____

STUDENT NAME: _____ GENDER: M / F

DOB: _____ AGE: _____ GRADE: _____

STUDENT NAME: _____ GENDER: M / F

DOB: _____ AGE: _____ GRADE: _____

STUDENT NAME: _____ GENDER: M / F

DOB: _____ AGE: _____ GRADE: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____

MOTHER/CARETAKER NAME: _____

PHONE #: _____ EMAIL: _____

FATHER/CARETAKER NAME: _____

PHONE #: _____ EMAIL: _____

PICK UP/DROP OFF LOCATION

ADDRESS: _____

STUDENTS UNDER 12 WILL NOT BE DROPPED OFF WITHOUT SOMEONE PRESENT (LIST BELOW)
AUTHORIZED PEOPLE WHO CAN RECEIVE STUDENTS UNDER 12

EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____ PHONE#: _____

NAME/RELATIONSHIP: _____ PHONE#: _____

SPECIAL ACCOMMEDATIONS:(CIRCLE)

BRACES CARSEAT OXYGEN HARNESS SCOOTER WALKER WHEEL CHAIR CRUTCHES

MEDICAL CONCERNS: _____

ALLERGIES: _____

PARENT/GUARDIAN SIGNATURE _____ DATE: _____

CMCSS STAFF SIGNATURE: _____ DATE: _____