

**Haverhill Public Schools
Transportation Department
SPECIAL TRANSPORTATION REQUEST
(Request Requires 72 Hours Notice)**

Date: _____

SCHOOL YEAR: _____

ADD ON ___ DELETION ___ CHANGE ___ OUT OF DISTRICT ___ DCF ___ PRE-SCHOOL ___

I.

Student: _____ D.O.B.: _____
Parent/Guardian: _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____
Street Address: _____ City/Town: _____
Emergency Contact: _____ Emergency Phone: _____
Relationship to Student: _____ Alternative Drop Off: _____

II.

School Name: _____ School Address: _____
Phone Number: _____ Contact Person: _____
Start Date: _____ Ending Date: _____
Days of the Week: _____
Other: _____

III. Special Conditions:

___ Wheelchair ___ Monitor ___ Car Seat/Booster ___ A/C
Is the child a danger: ___ To himself/herself ___ Others ___ Flight Risk (Runner)

IV. Medical Conditions:

Seizures: ___ Yes ___ No Allergies: ___ Yes ___ No Non Verbal: ___ Yes ___ No
Emotional/Behavioral Difficulties: ___ Yes ___ No Sensory Loss (*Hearing/Vision*): ___ Yes ___ No
Other: _____

Administrative Signature: _____ Date: _____

To be Completed by Transportation Department:

Date Received: _____
Name of Company Assigned: _____ Phone Number: _____
Cost: _____ Placement Date: _____
Additional Information:

Input: _____