SPECIAL TRANSPORTATION

620-473-2257

Student Name	District School	Pre-K Only AM - PM
		AM PM
		AM PM
		AM PM

Parent's Name_____

Address: _____

City: _____ Zip: _____

Phone Number- Home: _____ Work: _____ Cell: _____

Pick up Location

Address: _____

City: _____ Phone: _____

Name of Adult at Location: _____

Drop off Location

Address: _____

City: _____ Phone: _____

Name of Adult at Location: _____

Please circle **Yes or No** to any current medical issue:

Yes	No	Choking/feeding issues
Yes	No	Ambulatory Needs (Wheelchair, Walker, Etc.)
Yes	No	Seizures
Yes	No	Asthma
Yes	No	Low/ High Blood Sugar Issues (Diabetic)
Yes	No	Allergies/ Epi-pen
Yes	No	Cardiac Issues
Yes	No	Heat/ Cold intolerance
Yes	No	Immunization records
Yes	No	Current Physical

List of Medications:

1. _____
2. _____
3. _____

Parents Signature: _____ Date: _____

R.N_____ Date: _____