Manchester Board of Education
45 North School Street
Manchester, CT 06042
Office: 860-647-3476
Fax: 860-647-5027

Request for Special Transportation

Section I (To be completed by Parent/Guardian)

Name: _____ School:_____ Grade: _____

Address: _____ Parent/Guardian: _____

Date of Request: _____ Home Phone: _____ Work Phone: _____

Section II (To be completed by Physician ONLY)

All Items Must Be Completed

Diagnosis and reason student cannot walk to school: _____

_____

Can student be transported safety? ☐ Yes ☐ No Is the student in a wheelchair? ☐ Yes ☐ No

Appropriate method of transportation suggested: ☐ Regular Bus ☐Minibus ☐ Lift Bus ☐Van

Other Limitations (i.e. Physical Education, School Sports, Recess, etc.): _____

_____

Special Equipment with student (i.e. knee immobilizer, crutches, etc): _____

_____

How long do you anticipate this special service will be needed? _____

Is student's diagnosis triggered by cold air? (i.e. winter only stop Dec 1, 2014-March 31, 2015) ☐ Yes ☐ No

Date of Examination: _____ Physician Phone: _____ Physician Fax: _____

Signed: _____ **Office: _____**

Office Use Only

Approved by: _____ Date of Approval: _____ Vehicle Information: _____