



VISTA UNIFIED SCHOOL DISTRICT
TRANSPORTATION FORM
Special Education Department

SPED Sup Approval: _____
Date: _____

Date of Request _____
Student: _____ DOB: _____ Grade: _____ ID# _____
Address: _____ City/ Zip: _____
Parent/ Guardian: _____ HM. Phone: _____
Wk. Phone: _____ Additional Contact #: _____
Home School: _____ School of Attendance: _____
Home Language: _____ Program Placement: _____ IEP Date: _____
Projected Service Start Date: _____ School Days/Hours: _____
TYPE: Round Trip A.M. Only P.M Only Closest Public Access
Student must be met by an adult at residence or school: Yes No

Release Authorization: Name: _____ Relationship: _____ Phone: _____
Emergency Contact: Name: _____ Relationship: _____ Phone: _____
Parent/Guardian Signature: _____ Date: _____

PICK-UP ADDRESS: _____ **DELIVERY ADDRESS:** _____
Address: _____ Address: _____
City/ Zip: _____ City/Zip: _____
CONTACT PERSON: _____ CONTACT PERSON: _____
Comments: _____

DISTRICT USE ONLY:

- Wheelchair dependent Walker dependent Requires assistance loading/unloading
- Safety Vest D-Ring Special Aide/ Nurse required Must be met by an adult at residence or school
- Possible problem with other children Behavior Plan Diabetic Subject to seizures
- Requires medication Special equipment Ride time limitations Special bus requirements

TRANSPORTATION DEPT. USE ONLY:

DATE RECEIVED: _____ START DATE: _____
A.M. Pick- Up Location: _____ Route #: _____ Time: _____
P.M. Drop- Off Location: _____ Route #: _____ Time: _____