PLAINEDGE PUBLIC SCHOOLS
Guidance Department

REQUEST FOR SPECIAL TRANSPORTATION

2013-2014 School Year

Student's Name:_____ Date Of Application:_____
First (Please Print) Last

School:_____ Grade:_____

Parent's of Guardian's Name: _____(_____)_____
First (Please Print) Last Telephone Number

Home Address:_____

Reason for Special Bus Service:_____

Parent's or Guardian's Signature:_____

TO BE COMPLETED BY DOCTOR;

Doctor's Name: _____
First (Please Print) Last

Address:_____Telephone Number( )_____

Medical Diagnosis and Other Relevant Information:_____

_____

_____

Special Bus Service Needed: □ Yes □ No

Bus To Pick Up At: □ Home □ Nearest Bus Stop

Date of Service: From: _____ To: _____
Month/Day Month/Day

_____ Date:_____
Physician's Signature

Approved By: _____
Verdel A. Jones
Director of Guidance

VJ:jc
8/10
Jcacioli/forms/medialtransp2013-2014