Student Transportation Card

A.M. Stop____________
approx time

School_______________________________

P.M. Stop____________
approx time

Bus #_______ Grade_______

Bus Driver___________________________

Student's Name:____ Age_________Date of Birth ____________

Address____ Home Phone:_____________________

Parents Phone: ____

Other Contacts:____

Names and Addresses of Persons Nearby Student's Residence Who Have Parental Permission to Care for the Student if the Parents are not Available:

Name ________________________ Name ________________________ Name ________________________

Address_______________________ Address_______________________ Address_______________________

_______________________ _______________________ _______________________

Phone ________________________ Phone ________________________ Phone ________________________

Please Check if any of the Following Applies to Your Child:____Asthma ____Heart Disease ____ Diabetes

____Chronic Respiratory Problems ____Blind ____Deaf ____Non-Verbal ____Bee Sting ____Hemophiliac

____Allergies- to what?______________________________ Seizures: How long does it last? _____________

How often do they occur?________________ Action needed, if any:_________________________________

Is your child on medication?_____Yes ______No; If yes, what medication, what dosage, and when given:

____

Family Doctor:____________________________Address:____

Doctor's Phone#____________________Family Designated Hospital:______________________________

Date:____________________ Parent or Guardian's Signature_____________________________________

(OVER)