Individual Transportation Checklist
Special Needs Transportation Evaluation Report

Student Name:_____ **Date of Birth**_____
Address:_____
City:_____ **Telephone**_____

Program:_____

Supervision/Assistance: Specify level of supervision/assistance necessary i.e. verbal cue, hand held, continual, etc. and who should provide the needed supervision and/or assistance._____
_____

Equipment:
____Child safety seat: Booster or car seat Indicate type if known_____
____Weight _____Height
____Wheelchair Indicate type if known_____
____Harness Indicate type if known_____
____Other: Specify _____

Medical/Behavioral Information:

___ There is no known problem or condition which would cause any difficulty transporting this student
___ Medical crisis intervention plan (attached)
___ Behavioral intervention plan (attached)
___ Deaf and/or Hearing Impaired
___ Blind and/or Visually Impaired
___ Limited speech
___ Non-verbal
___ Intellectually Impaired
___ Occasional emotional outbursts
___ Difficult to control
___ Additional Personnel Needed: Reason Why:_____
_____
___ Seizure precautions: Specify _____
___ Asthma precautions: Specify _____
___ Shunt precautions: Specify_____
___ Alternate communication: Specify_____
___ Allergy precautions: Specify _____
___ Fragile Bones or other orthopedic condition precautions: Specify _____
_____
___ Medication side effects (i.e. falls asleep easily, sensitive to sunlight, etc.): Specify _____
___ Significant swallowing difficulty/choking concerns
___ Other: Specify_____