

REQUEST FOR COORDINATED **SPECIAL EDUCATION SY 2010-2011** TRANSPORTATION  
**MOESC** • 900 Hope Rd • Tinton Falls, NJ 07712 • 732.695.7805 • FAX 732.493.6435/732.493.5120 [www.moescschoolbus.org](http://www.moescschoolbus.org)  
(SEPTEMBER-JUNE)

Submit a separate request for each student requiring transportation services NO LATER THAN 6/1/10

DISTRICT REQUESTING TRANSPORTATION \_\_\_\_\_

TRANSP START DATE \_\_\_\_\_ END DATE \_\_\_\_\_

STUDENT NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET (MUST be actual street address) CITY ZIP

PARENT/GUARDIAN \_\_\_\_\_ HOME PHONE # \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ DOB \_\_\_\_\_ GRADE \_\_\_\_\_ SEX \_\_\_\_\_

Where should student be picked up: \_\_\_\_\_ Phone: \_\_\_\_\_ Contact: \_\_\_\_\_  
(if different from home address)

Where should student be dropped off: \_\_\_\_\_ Phone: \_\_\_\_\_ Contact: \_\_\_\_\_  
(if different from home address)

SCHOOL OF ATTENDANCE \_\_\_\_\_ Bldg #: \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE: \_\_\_\_\_

STUDENT'S DAILY SCHEDULED HOURS \_\_\_\_\_ AM/PM -- TO \_\_\_\_\_ AM/PM

Does this student's I.E.P. REQUIRE the assignment of an aide on the vehicle? Yes \_\_\_\_\_ No \_\_\_\_\_  
If YES, does this student's I.E.P REQUIRE a one-to-one aide on the vehicle? Yes \_\_\_\_\_ No \_\_\_\_\_

Please check if your district requests the assignment of an aide to assist all children on the vehicle \_\_\_\_\_  
(not required by IEP)

OTHER INFORMATION/COMMENTS NEEDED TO ENSURE THE HEALTH & SAFETY OF THE STUDENT:  
\_\_\_\_\_  
\_\_\_\_\_

Student's Classification \_\_\_\_\_

Wheelchair: Standard \_\_\_\_\_ Motorized \_\_\_\_\_ Stroller-Type \_\_\_\_\_ Other: \_\_\_\_\_

Car Seat: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, Age: \_\_\_\_\_ Weight: \_\_\_\_\_

Booster Seat: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, Age: \_\_\_\_\_ Weight: \_\_\_\_\_

Subject to Seizures? Petite Mal \_\_\_\_\_ Grand Mal \_\_\_\_\_

Braces, Crutches or Walker: (specify) \_\_\_\_\_

Does the student require an Air Conditioned Vehicle? Yes \_\_\_\_\_ No \_\_\_\_\_

Allergies: Latex \_\_\_\_\_ Peanut \_\_\_\_\_ Bee Sting \_\_\_\_\_ Other \_\_\_\_\_

EMERGENCY CONTACT PERSON \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHONE: \_\_\_\_\_ ADDITIONAL EMERGENCY PHONE: \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE/TITLE

\_\_\_\_\_  
Date

Note: Your district will be billed until Written notification to cancel this request for transportation is received. No exceptions will be made.

**FOR MOESC USE ONLY:**

ROUTE #: \_\_\_\_\_  
ROUTE # \_\_\_\_\_

CONTRACTOR: \_\_\_\_\_ (TO SCHOOL)  
CONTRACTOR: \_\_\_\_\_ (FROM SCHOOL)

