CAMDEN COUNTY EDUCATIONAL SERVICES COMMISSION
FAX #: 856 – 309 - 1026

______________________ BOARD OF EDUCATION

APPLICATION FOR SPECIAL EDUCATION TRANSPORTATION

PLEASE COMPLETE ALL INFORMATION   Date of Birth ____/____/______________

Pupil's Name ____ Grade ___________________

Address ____

____

Parent/Guardian _______________________________________ Telephone #________________

EMERGENCY CONTACT NAME AND # ____
(must be supplied)

School Attending ____

School Address ____

School Hours __________ AM __________ PM Telephone # _______________________

Date to begin ____

To provide transportation for this pupil is contained in the IEP? ____ Yes ____ No

Please check any of the following items necessary:

Wheelchair Lift ___________________________

Shared Aide on Bus ___________________________

1 on 1 Aide Required ___________________________

Seizures ___________________________

Uses Braces ___________________________

Other ___________________________

NOTE: THIS APPLICATION IS ACCEPTED AND TRANSPORTATION WILL BE ARRANGED IN ACCORDANCE WITH THE COMMISSION'S POLICY TO APPORTION COST ON A MONTHLY BASIS. YOUR DISTRICT WILL BE BILLED ON THIS BASIS UNTIL WRITTEN NOTIFICATION TO CANCEL THIS REQUEST FOR TRANSPORTATION IS RECEIVED BY THE COMMISSION.

____   ____
(District Authorized Signature)   (Date)

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Date received by Commission _____________________________   Contractor Name

Assigned to Route Number _____________________________   _____________________________

THIS APPLICATION SHOULD BE FILED AT LEAST ONE WEEK BEFORE TRANSPORTATION IS TO COMMENCE.

Revised 2/7/05