

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 _____

State ID Number _____
(*must be supplied)

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)

Date received by Commission _____ Contractor Name _____

Assigned to Route Number _____

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

***Application will not be processed without this information)**