



St. James-Assiniboia School Division APPLICATION FOR STUDENT TRANSPORTATION

PLEASE PRINT. Complete and return this form to the school. Contact the school office with any questions or concerns.

School: _____ Date of Application: _____

STUDENT INFORMATION

DATE TRANSPORTATION TO BEGIN: _____

Last Name: _____ First Name: _____ Male Female

Home Address: _____

Phone Number: _____ Grade: _____ Birthdate: Day _____ Mo _____ Yr _____

Mother's Name: _____ Work #: _____

Father's Name: _____ Work #: _____

Emergency Contact Name: _____ Phone Number: _____

TRANSPORTATION ADDRESS INFORMATION: same as above or,

Daycare Address: _____

Daycare/Caregiver's Name: _____ Phone Number: _____

SIGNATURE OF CAREGIVER (IF APPLICABLE)

SIGNATURE OF PARENT

(Parent and Caregiver must sign verifying that care is being provided for one hour or more per day as per policy EEA.)

MEDICAL/EXCEPTIONAL NEEDS INFORMATION: Health Care Needs: No Yes (If yes, please complete the following)

Allergies: EpiPen Yes No

Asthma: Inhaler Yes No

Seizures

Diabetes

Other, please specify: _____

Description of Service: Regular Wheelchair Access Other: _____

Student pick-up and drop-off: No supervision required Someone must be at stop to receive student

Description of Exceptional Needs (include emergency procedures, notes, etc.): _____

PRINCIPAL'S USE ONLY: PLEASE ONE OF THE FOLLOWING FOR ELIGIBILITY (FROM POLICY EEA & EEA-R)

ELIGIBLE RIDER

EXCEPTIONAL NEEDS/SPECIAL PROGRAM

PURCHASE SEAT - *POST DATED CHEQUES must be attached*

COORDINATOR OF STUDENT SERVICES (IF APPLICABLE)

PRINCIPAL/DESIGNATE

TRANSPORTATION SUPERVISOR

Incomplete forms will not be processed and will be returned to the school.