



220 North Main Street
 Suite 106
 Natick, MA 01760
 508.620.3875
 Fax 508.620.2897

Please complete all information requested and return to ACCEPT Transportation. **THIS FORM MUST BE COMPLETED ANNUALLY BEFORE THE START OF TRANSPORTATION SERVICES. THANK YOU!**

TRANSPORTATION HEALTH AND EMERGENCY INFORMATION 2016-2017

STUDENT NAME: _____ DATE OF BIRTH: _____
LAST FIRST MI

HOME ADDRESS: _____
STREET CITY STATE ZIP

PARENT/GUARDIAN NAME: _____ EMAIL ADDRESS _____
LAST FIRST

PHONE: HOME _____ CELL _____ WORK _____

PARENT/GUARDIAN NAME: _____ EMAIL ADDRESS _____
LAST FIRST

PHONE: HOME _____ CELL _____ WORK _____

PLEASE CHECK IF APPROPRIATE:	IF CHECKED, PLEASE EXPLAIN IN SPACE PROVIDED
<input type="checkbox"/> ASTHMA INHALER ___YES ___NO	
<input type="checkbox"/> ALLERGIES EPI-PEN ___YES ___NO	
<input type="checkbox"/> BEHAVIORAL ISSUES	
<input type="checkbox"/> DIABETES	
<input type="checkbox"/> FEEDING TUBE	
<input type="checkbox"/> HEARING LOSS <input type="checkbox"/> VISION LOSS	
<input type="checkbox"/> SEIZURE DISORDER/EPILEPSY	
<input type="checkbox"/> SWALLOWING DIFFICULTIES	
<input type="checkbox"/> PHYSICAL CHALLENGES	
<input type="checkbox"/> OTHER	

I acknowledge that I am required to provide a car or booster seat in accordance with the regulations in the handbook. My child requires a car seat? NO YES My child requires a booster seat? NO YES

If your child is less than 12 years old he/she must have parental supervision to transition on the van in the morning and off the van in the afternoon.

If your child is 12 or older, is s/he able to be left alone? NO YES

Please note: If you checked Yes, it indicates that you give permission for your child to be home alone. Neither ACCEPT nor the District will be responsible for any occurrences once the student is dropped off.

I have received the ACCEPT Transportation Manual YES NO

I understand that for safety and training purposes there may be audio/video devices on board the vehicle YES

EMERGENCY CONTACTS: (other than Parent/Guardian in case Parent is not available)

NAME: _____ RELATIONSHIP (Not Parent) _____

PHONE: HOME _____ CELL _____ WORK _____

PHYSICIAN NAME: _____ PHONE _____

The above named physician is authorized to release necessary medical information in the event of an emergency. YES NO

Parents are responsible for notifying the Transportation Coordinator if any of the information above changes.

PARENT/GUARDIAN Signature: _____

DATE: _____

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