



**Manchester Board of Education**  
**45 North School Street**  
**Manchester, CT 06042**  
**Office: 860-647-3476**  
**Fax: 860-647-5027**

**Request for Special Transportation**

**Section I (To be completed by Parent/Guardian)**

Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_

Date of Request: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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**Section II (To be completed by Physician ONLY)**

*All Items Must Be Completed*

Diagnosis and reason student cannot walk to school: \_\_\_\_\_

Can student be transported safely?  Yes  No Is the student in a wheelchair?  Yes  No

Appropriate method of transportation suggested:  Regular Bus  Minibus  Lift Bus  Van

Other Limitations (i.e. Physical Education, School Sports, Recess, etc.): \_\_\_\_\_

Special Equipment with student (i.e. knee immobilizer, crutches, etc): \_\_\_\_\_

How long do you anticipate this special service will be needed? \_\_\_\_\_

Is student's diagnosis triggered by cold air? (i.e. winter only stop Dec 1, 2017-March 31, 2018)  Yes  No

Date of Examination: \_\_\_\_\_ Physician Phone: \_\_\_\_\_ Physician Fax: \_\_\_\_\_

**Signed:** \_\_\_\_\_

**Office:** \_\_\_\_\_

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**Office Use Only**

**Approved by:** \_\_\_\_\_ **Date of Approval:** \_\_\_\_\_ **Vehicle Information:** \_\_\_\_\_