



Manchester Public Schools Individualized Transportation Plan

Student:	Address:	DOB:
Parent/Guardian:	Cell:	Other:
Parent/Guardian:	Cell:	Other:
Emergency Contact:	Cell:	Other:
School:	Grade:	School Phone:
Daycare/Sitter Name:	Address:	Phone:
Check all that apply:	Enter any necessary notes/information:	
<input type="checkbox"/> Behavior		
<input type="checkbox"/> Breathing Problem		
<input type="checkbox"/> Car Seat/Star Seat		
<input type="checkbox"/> Communication (hearing/speech)		
<input type="checkbox"/> Harness		
<input type="checkbox"/> Monitor/Aide		
<input type="checkbox"/> Physical Need/limitation		
<input type="checkbox"/> Seat Belt		
<input type="checkbox"/> Seizure		
<input type="checkbox"/> Severe allergy/anaphylaxis		
<input type="checkbox"/> Special Seat Placement		
<input type="checkbox"/> Vision limitation		
<input type="checkbox"/> Wheelchair		

Add any additional pertinent information:

Person who completed this plan: _____ **Title:** _____

Date Completed: _____