REQUEST FOR TRANSPORTATION CHANGE

Name of Parent/Guardian:_______________________________________ **Date:**______________

Name of Student:________________________ **School: HS MS AR FR LV Falls Secor (Please circle)**
Grade:___________

Telephone (Home):________________ **Telephone (Work):**________________

Address: ____
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Transportation Request: Medical Safety and Health (Please circle)

Describe Reason for Change: Duration of Transportation Change: ________________**(Please indicate)**

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(If Medical, please provide a detailed Evaluation and Explanation on the physicians letterhead. The District may require an independent medical evaluation. Non medical transportation requests must be supported by documentation included with this form)

(If Safety and Health, please complete the attached exception criteria form.)

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Signature of Parent / Guardian

Request Status:

Approved **Not Approved**

____ __________________
Director of Transportation: Date:

Approved **Not Approved**

____ __________________
Assistant Superintendent Date:

Approved **Not Approved**

____ __________________
Superintendent Date:

Reason for Denial:

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THIS FORM MUST BE FILED ANNUALLY
This change expires at the end of the duration period
Further exemptions require re-filing of this form.