

Checklist for Special Transportation Eligibility

___ Initial IEP ___ Annual Review ___ IEP Review ___ Amendment

Student Name: _____
Parent Name: _____
Address: _____
School of Attendance: _____

Start Date: _____
Mom Cell Phone: _____
Dad Cell Phone: _____
Grade: _____

JUSTIFICATION FOR TRANSPORTATION:

Check all statements that apply:

___ Student needs to attend a school other than his/her home school to receive services deemed necessary by the IEP Team AND home school is more than 1.5 miles from student's home address. School of Residence: _____

___ Student needs to attend home school to receive services deemed necessary by the IEP Team AND home school is more than 1.5 miles from the student's home address AND no regular transportation is provided to general education students.

___ Student is eligible for Extended School Year services which are located at a school other than the school of residence. Transportation applies only to ESY.

___ A medical report documents that the student has a physical disability or severe health condition that prevents him/her from getting to school independently. Disability or health condition: _____

___ The student uses technology or assistive device such as a helmet, ventilator, oxygen, tracheotomy tube, or frequent suctioning as defined in the student's health plan.

___ The student has uncontrolled seizures, severe hypotonia causing obstructed airway or apnea.

___ The student uses a walker, manual wheelchair, or powerchair. Describe, including width: _____

___ The student needs an adapted car seat, safety vest, or seat restraint. Give the student's age and weight (to get the appropriate car seat or restraint size) _____

___ The student has equipment or medication that is to be transported daily. Explain: _____

___ The student has a behavior/emotional disability that is so severe or erratic that there is concern for the safety of the student and/or others.

___ The Behavior Intervention Plan lists strategies and supports for bus behavior.

___ The student needs an adapted car seat, safety vest, or seat restraint. Give the student's age and weight (to get the appropriate car seat or restraint size) _____

___ Transportation needs to be provide on a temporary basis from ___/___/___ to ___/___/___.

Reason: _____

___ Other/Please specify reason: _____

BASED ON THE ABOVE CHECKLIST, THE IEP TEAM HAS DETERMINED THAT THE STUDENT QUALIFIES FOR SPECIAL TRANSPORTATION.

___ YES ___ NO

FORM COMPLETED BY: _____

DATE: ___/___/___

PERSON RESPONSIBLE FOR NOTIFYING CINDY JOHNSON (815-683-2662 or cjohnson@iroqsea.org) OF THE NEED FOR SPECIAL TRANSPORTATION: _____

***Include this checklist with all IEPs where special transportation is needed**