TRANSPORTATION HEALTH INFORMATION SHEET (TRA-F010)

Sacramento City Unified School District

1	NAME:	BOY G	RL SCHOOL:
ADDRESS:		Home Phone:	Pager/Cell Phone:
CITY:			
CITY:	ADDRESS:		
FATHER/GUARDIAN: WORK PHONE: MOTHER/GUARDIAN: WORK PHONE: Preson(s) to be called in emergencies when a parent cannot be reached: Name: Phone:			
MOTHER/GUARDIAN: WORK PHONE: Person(s) to be called in emergencies when a parent cannot be reached: Name: Phone:	EATHER/CHARDIANI	MODE DHOME	
Person(s) to be called in emergencies when a parent cannot be reached: Name:			
Name:			
Name:	()	'	
Physician:			
MAY YOUR CHILD BE DROPPED OFF WITHOUT ADULT SUPERVISION			
If a parent is not home, who may take the child off the bus? 1	Physician:	Phone:	
If a parent is not home, who may take the child off the bus? 1	MAY YOUR CHILD BE DROPPED OFF WITH	OUT ADULT SUPERVISION	yes no
2			- · ·
Other:			
Other:	Wheelshair was no / Harness	vos no / Polluband vos /	no / Vert ves no / Car Seat ves no
Equipment to be transported: IMPORTANT MEDICAL INFORMATION: BREATHING PROBLEMS		_ yes 110 / bellyballu yes / 1	10 / Vest yes 110 / Car Seat yes 110
IMPORTANT MEDICAL INFORMATION: BREATHING PROBLEMS			
BREATHING PROBLEMS SCOLOISIS / "ROD" SURGERY ASTHMA SCOLOISIS / BRACE ASTHMA DIABETES BILIND / VISUALLY IMPAIRED HEART CONDITION WHAT IS SAID SYNDROME: SEIZURES: Yes No How frequent are the seizures: When was the last seizure: // // If yes, please describe seizure: ALLERGIES: (Please list) ALLERGIES: (Please list) ALLERGIES TO MEDICATION: (Please list) MEDICATION(S): Yes No 1. 3. 4. SPECIAL HEALTH/SAFETY PRECAUTIONS: (lifting, helping child to walk, etc.) TRAYEL ENDURANCE: HEAT ENDURANCE: 1. 2. 3. PERMISSION FOR EMERGENCY CARE: In the event of an accident or other emergency when a parent is not available, I hereby authorize a representative of the school district to make such arrangements as he/she considers necessary for my child to receive medical or hospital care, including necessary transportation.	• • • • • • • • • • • • • • • • • • • •		
SCOLOISIS / "ROD" SURGERY GASTROSTOMY TUBE SHUNT(S) SCOLOISIS / BRACE ASTHMA CHALLENGING BEHAVIOR NON VERBAL			
SCOLOISIS / BRACEASTHMACHALLENGING BEHAVIORDIABETESVERBALNON VERBALNON VERBALNON VERBAL			
BLIND / VISUALLY IMPAIREDHEART CONDITIONNON VERBAL BUT UNDERSTANDSTRAGILE BONES"		ASTHMA	
SYNDROME: SEIZURES:YesNo How frequent are the seizures: When was the last seizure:// If yes, please describe seizure: ALLERGIES: (Please list) ALLERGIES TO MEDICATION: (Please list) MEDICATION(S):YesNO 1 3 2 4 SPECIAL HEALTH/SAFETY PRECAUTIONS: (lifting, helping child to walk, etc.) TRAVEL ENDURANCE: HEAT ENDURANCE: 1 2 3 PERMISSION FOR EMERGENCY CARE: In the event of an accident or other emergency when a parent is not available, I hereby authorize a representative of the school district to make such arrangements as he/she considers necessary for my child to receive medical or hospital care, including necessary transportation.			
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ALLERGIES TO MEDICATION: (Please list) MEDICATION(S):YesNo 1			
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1	ALLERGIES TO MEDICATION: (Please list)		
2	MEDICATION(S):YesNo		
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to make such arrangements as he/she considers necessary for my child to receive medical or hospital care, including necessary transportation.			ble. I hereby authorize a representative of the school district
(Signature of Parent / Guardian) (Date)	to make such arrangements as he/sl transportation.	ne considers necessary for my chil	d to receive medical or hospital care, including necessary
	(Signature of I	 Parent / Guardian)	(Date)

09/1998; Rev A 08/16/12; Rev B TRA-F010

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