

TRANSPORTATION HEALTH INFORMATION SHEET (TRA-F010)

Sacramento City Unified School District

NAME: _____ BOY ___ GIRL ___ SCHOOL: _____

(Last) (First)
BIRTH DATE: ___/___/___
Mo Day Yr

Home Phone: _____ Pager/Cell Phone: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

FATHER/GUARDIAN: _____ WORK PHONE: _____

MOTHER/GUARDIAN: _____ WORK PHONE: _____

Person(s) to be called in emergencies when a parent cannot be reached:

Name: _____ Phone: _____

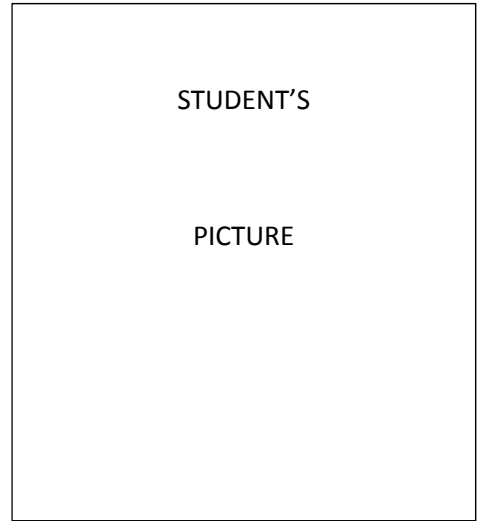
Name: _____ Phone: _____

Physician: _____ Phone: _____

MAY YOUR CHILD BE DROPPED OFF WITHOUT ADULT SUPERVISION _____ yes ___ no

If a parent is not home, who may take the child off the bus? 1. _____

2. _____ 3. _____



Wheelchair ___ yes ___ no / **Harness** ___ yes ___ no / **Bellyband** ___ yes / ___ no / **Vest** ___ yes ___ no / **Car Seat** ___ yes ___ no

Other: _____

Equipment to be transported: _____

IMPORTANT MEDICAL INFORMATION:

- | | | |
|--|--|--|
| <input type="checkbox"/> BREATHING PROBLEMS | <input type="checkbox"/> CEREBRAL PALSY | <input type="checkbox"/> TRACHEOSTOMY |
| <input type="checkbox"/> SCOLIOSIS / "ROD" SURGERY | <input type="checkbox"/> GASTROSTOMY TUBE | <input type="checkbox"/> SHUNT(S) |
| <input type="checkbox"/> SCOLIOSIS / BRACE | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> CHALLENGING BEHAVIOR |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> VERBAL | <input type="checkbox"/> NON VERBAL |
| <input type="checkbox"/> BLIND / VISUALLY IMPAIRED | <input type="checkbox"/> HEART CONDITION | <input type="checkbox"/> NON VERBAL <u>BUT</u> UNDERSTANDS |
| <input type="checkbox"/> "FRAGILE BONES" | <input type="checkbox"/> DEAF / HEARING IMPAIRED | 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 TO MEDICATION: (Please list) _____

MEDICATION(S): ___ Yes ___ No

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.

(Signature of Parent / Guardian)

(Date)