This form required for transportation ITP-1

INDIVIDUAL TRANSPORTATION PLAN (ITP)

Emergency Medical Data

STUDENT NAME: ______________________ **DATE OF BIRTH:** ______________

STUDENT ID#: __________ **HEIGHT:** ______ **WEIGHT:** ______ **SCHOOL DISTRICT:** ______________

ADDRESS: ______________________ **CITY:** ______________ **ZIP:** ________

PHONE: ______________________ **ALTERNATE PHONE:** ______________________

PROGRAM: __________ **SCHOOL OF ATTENDANCE:** ______________ **SCHOOL YEAR:** __________

PASSENGER CONDITIONS: Does the student / passenger have any of the following conditions or needs?

	Yes	No	Unknown	Comment:
Crisis or behavior management plan in place at school?	☐	☐	☐	
Health Management plan in place at home or school?	☐	☐	☐	
Specify medical conditions:				
Asthma or other Respiratory Condition	☐	☐	☐	
Cardiac Problem	☐	☐	☐	
Allergies (latex, insect bites/stings, etc.)	☐	☐	☐	
Shunt (specify location)	☐	☐	☐	
Spinal Rod, Fragile Bones or other Ortho. Needs	☐	☐	☐	
Wheelchair (identify type/brand name if known)	☐	☐	☐	
Oxygen, Ventilator, Artificial airway	☐	☐	☐	
Seizure prone	☐	☐	☐	
Feeding tube or significant swallowing problems	☐	☐	☐	
Other Health Conditions (explain in comments)	☐	☐	☐	
Uses speech (note if other than English)	☐	☐	☐	
Uses communication prosthesis	☐	☐	☐	
Uses sign language primarily	☐	☐	☐	
Uses adaptive equipment (walker, tray, crutches, etc)	☐	☐	☐	
Uses car seat, vest, or specialized occupant restraint	☐	☐	☐	

Identify any other concerns not listed above that the student might experience: ______________________

EMERGENCY EVACUATION: Specify Emergency Evacuation Precautions to be considered.

____

SPECIFIC PICK-UP or DROP-OFF PROCEDURES: ______________________

NOTIFICATION TO PARENT/GUARDIAN: If there are any changes in your child's medical or behavioral status which you believe may merit changes in staffing, precautions to be taken, interventions, restraints, or any other procedure discussed above, contact the appropriate District Administration..
If a student utilizes a wheelchair, a "Wheelchair Review Checklist" will be completed and attached as an addendum to the ITP.
A change in residency (a new address) requires a three (3) day notification to the District Administrator..

______________________ ______________________
Parent/Guardian Date Program Supervisor Date

For school use ONLY

This report has been reviewed for accuracy with notations and or modifications made as necessary

Building: __________ **Classroom:** __________ **Teacher Signature:** ______________

EMERGENCY MEDICAL AUTHORIZATION FORM

STUDENT NAME: ______________________ **DATE OF BIRTH:** ____________

SOCIAL SECURITY # OR STUDENT ID #: ____________ **SCHOOL DISTRICT:** ____________

ADDRESS: ______________________ **CITY:** ____________ **ZIP:** ________

PHONE: ____________ **ALTERNATE PHONE:** ____________

Purpose -- To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian

Mother's Name ______________________ Daytime Phone ____________
Alternate Phone ____________

Father's Name ______________________ Daytime Phone ____________
Alternate Phone ____________

Other's Name ______________________ Daytime Phone ____________
Alternate Phone ____________

Name of Relative or Childcare Provider

Name ______________________ Relationship ____________

Address ______________________ Daytime Phone ____________

****EITHER PART I OR PART II MUST BE COMPLETED****

PART I: TO GRANT CONSENT **I hereby give consent for the following medical care providers and local hospitals to be called:**

Physician ______________________ Phone ____________

Dentist ______________________ Phone ____________

Medical Specialist ______________________ Phone ____________

Local Hospital ______________________ Emergency Room ____________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization DOES NOT cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the procedure.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments as listed:

____

____

Date: ____________ **Signature of Parent/Guardian:** ______________________

PART II: REFUSAL TO CONSENT **I DO NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:**

Date: ____________ **Signature of Parent/Guardian:** ______________________