Lincolnshire-Prairie View School District 103
Transportation Services

STUDENT INFORMATION CARD

STUDENT ID# _____ NAME: _____ NICKNAME: _____ AGE: _____

Class/Program: _____ Case Manager: _____

** General address, guardian, and contact information will be taken from Power Schools.*

TRANSPORTATION INFORMATION

PICK-UP INFORMATION: _____ _____
(NUMBER & STREET NAME) (APT #) (CITY) (PHONE)

If this is a daycare, please indicate name of facility: _____

DROP OFF INFORMATION: _____ _____
(NUMBER & STREET NAME) (APT #) (CITY) (PHONE)

If this is a daycare, please indicate name of facility: _____

Who will meet the child at drop off: _____ _____
(NAME) (RELATIONSHIP)

Does student have a key, and may student let self into house? ☐ YES ☐ NO

STUDENT INFORMATION

Hearing impaired: ☐ YES ☐ NO Hearing aide(s): ☐ YES ☐ NO

Speech level: ☐ Normal ☐ Impaired ☐ Does not speak (Sign ☐ YES ☐ NO)

Vision: ☐ Normal ☐ Corrected (With ☐ Glasses ☐ Contact lenses) ☐ Blind

Language spoken/understood: _____

PHYSICAL DISABILITY: ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

EMOTIONAL DISABILITY: ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:

SPECIAL CONSIDERTATIONS/GENERAL COMMENTS FROM FAMILY:

GENERAL MEDICAL INFORMATION

Please check all of the following that apply to the child:

☐ Blind	☐ Deaf	☐ Heart Disease	☐ Tracheotomy
☐ Asthma	☐ Non-verbal	☐ Uses Cane	☐ Diabetes
☐ Autistic	☐ Wheelchair	☐ Brace(s)	☐ Hemophiliac

Does the student have a temperature sensitivity? If so, please provide the low and high range:

No lower than: _____ degrees. No higher than: _____ degrees.

ALLERGY INFORMATION

Is student allergic to food? (Explain:) _____

☐ Bee Stings ☐ Other known allergies: _____

SEIZURE INFORMATION

Does the child experience seizures? ☐ YES ☐ NO If yes, complete all question in this section.

How often can they occur? _____

How long do the seizures normally last? _____

Describe the child's seizure behavior: _____

What is normal treatment for the child:

1. During seizures? _____
2. After seizures? _____

SPECIALIZED EQUIPMENT REQUIREMENTS

Does student use a wheelchair or scooter? ☐ YES ☐ NO If yes, please check all that apply to this device.

Equipment is: ☐ Manual ☐ Electric ☐ 3-Wheel Scooter ☐ 4-Wheelchair ☐ Tilt-in-space chair

Make & Model of Equipment _____ Does student use lap tray? ☐ YES ☐ NO

Does student use a walker? ☐ YES ☐ NO Will oxygen need to be transported? ☐ YES ☐ NO

Child requires special seating? ☐ YES ☐ NO If yes, please select seating below.

☐ Seat belt ☐ Safety Vest ☐ Infant Only Seat ☐ Convertible Car Seat ☐ Booster Seat

☐ Standard STAR System ☐ STAR Plus System ☐ STAR Special Needs Seat

**See transportation department website for details. www.d103.org/transportation*

Form completed by: _____ *Contact Number:* _____ *Date:* _____