

PARENT SURVEY FOR STUDENTS WITH MEDICAL NEEDS

STUDENT NAME: _____ Date: _____

Address _____
(No) (Street) (City) (State) (Zip)

School _____ Date of Birth _____

Mother/Guardian _____ Home Phone _____

Work Phone _____ Cell Phone _____

Father/Guardian _____ Home Phone _____

Work Phone _____ Cell Phone _____

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ALTERNATIVE TRANSPORTATION INFORMATION

Is the student being transported to or from a babysitter? Yes or No (Circle One)

BABYSITTER NAME _____ PHONE _____

BABYSITTER ADDRESS _____
(No) (Street) (City) (State) (Zip)

If a babysitter is being used, you must fill out a Change in Transportation form, which you may obtain from your home school.

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STUDENT INFORMATION

Student's Way of Communicating _____

Health Problems (i.e. allergies, etc.) _____

Special Equipment needed to transport student _____

Special Equipment needed to be transported along with student _____

Current Medications _____

Possible Side Effects (i.e. Sweating, agitation, fatigue, etc.) _____

Special Medical Concerns (i.e. seizures, allergies, sensitivities, etc.) _____

Precautions that need to be followed _____

Possible behaviors noted when student is under stress _____

Possible ways of calming student if upset _____

Does student need assistance boarding bus? Yes or No (Circle One)

Explain assistance needed _____

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**PHYSICIAN INFORMATION**

Attending Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

(No) (Street) (City) (State) (Zip)

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ADDITIONAL COMMENTS/INFORMATION _____

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I, \_\_\_\_\_, give my written permission to release the information

(Print Name of Parent/Guardian)

necessary regarding my child(ren) for use by the North Syracuse Central School District  
Department of Transportation, 5520 East Taft Road, North Syracuse, New York 13212.

\_\_\_\_\_

(Signature of Parent/Guardian)

\_\_\_\_\_

(Date)