

**MOESC | COORDINATED TRANSPORTATION REQUEST**

Revised information:

100 Tornillo Way | Tinton Falls | NJ | 07712 | (v) 732.389.5555 |  
Send Completed and Signed Requests to busforms@moesc.org or fax 732.493.5120

Select Type of Transportation:

DISTRICT REQUESTING TRANSPORTATION: \_\_\_\_\_

TRANSPORTATION START DATE: \_\_\_\_\_ END DATE: \_\_\_\_\_ NJ STATE ID#  
10 digits MUST be entered \_\_\_\_\_

STUDENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street, City, Zip (Must be actual street address) MOTEL/HOTEL NAME (ROOM #)

PARENT/GUARDIAN: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMERGENCY CONTACT PERSON (other than listed above): \_\_\_\_\_ PHONE: \_\_\_\_\_

DOB: \_\_\_\_\_ GRADE: \_\_\_\_\_ CLASSIFICATION: \_\_\_\_\_ SEX: \_\_\_\_\_

Where should student be **picked up**: \_\_\_\_\_ Phone: \_\_\_\_\_ Contact: \_\_\_\_\_  
(if different from home address)

Where should student be **dropped off**: \_\_\_\_\_ Phone: \_\_\_\_\_ Contact: \_\_\_\_\_  
(if different from home address)

Is student allowed off vehicle without an adult present: Yes  No

SCHOOL OF ATTENDANCE: \_\_\_\_\_ Bldg #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

DAILY SCHEDULED SCHOOL HOURS: START TIME: \_\_\_\_\_ AM  PM  END TIME \_\_\_\_\_ AM  PM

Does this student's I.E.P. REQUIRE the assignment of an ASSIST-ALL AIDE on the vehicle?

Does this student's I.E.P. REQUIRE a ONE-TO-ONE (1:1) AIDE on the vehicle?

Does this student's I.E.P. REQUIRE the assignment of a NURSE on the vehicle?

If Yes, does the NURSE require transportation to/from his or her car?

Does this student attend Extended School Year (ESY)?

**\*\*AN ASSIST ALL AIDE WILL BE PLACED ON ALL PRESCHOOL ROUTES\*\***

**OTHER INFORMATION/COMMENTS NEEDED TO ENSURE THE HEALTH & SAFETY OF THE STUDENT:**

**SPECIAL TRANSPORTATION REQUIREMENTS:**

Vehicle Preference:

Type of Wheelchair

If "other" is selected

Braces  Walker  Crutches  Vest/Harness  student's shirt size \_\_\_\_\_ student's weight: \_\_\_\_\_ seatbelt lock:

Car Seat  Booster Seat  If yes, specify weight: \_\_\_\_\_

Allergies: Latex  Peanut  Bee Sting  Other Allergy: \_\_\_\_\_ Subject to seizures:

SIGNATURE/TITLE \_\_\_\_\_

DATE \_\_\_\_\_

**\*\*\* NOTE: Your district will be billed until a completed MOESC Notice of Cancellation (form) is received. No exceptions! \*\*\***

**FOR MOESC USE ONLY:**

ROUTE #: \_\_\_\_\_ CONTRACTOR: \_\_\_\_\_ (TO SCHOOL)  
ROUTE #: \_\_\_\_\_ CONTRACTOR: \_\_\_\_\_ (FROM SCHOOL)

**\*\* Submit a separate request for each student requiring transportation services \*\***