ALEXANDER CITY SCHOOLS
STUDENT TRANSPORTATION CARD

SCHOOL YEAR: _____

School: _____ Bus Decal: _____ Bus Driver: _____

Student Name: _____ DOB: _____ Grade: _____

Parent Name: _____

Home Address: _____

Home/Cell Phone #: _____ Work Phone #: _____

Pick up A.M. Address: _____

Drop Off P.M. Address: _____

Emergency Contact _____ Phone #: _____

EMERGENCY MEDICAL INFORMATION

Please circle if any of the following applies to your student:

Asthma Heart Disease Diabetes Hemophilia Vision Problems Hearing Problems Seizures

If seizures, what type: _____

How often do seizures occur? _____

Action to be taken when seizure occurs: _____

Allergies: (please list) _____

Medications: (Please list) _____

_____

Other health concerns: (please list) _____

*PLEASE NOTE: ALL INFORMATION ON THIS FORM WILL BE MAINTAINED IN STRICTEST CONFIDENTIALITY