

**SAN DIEGO UNIFIED SCHOOL DISTRICT**

**Date:** July 2, 2019

**To:** Site Administrators, Division and Department Heads

**Subject:** REQUESTS FOR STUDENT TRANSPORTATION UNDER SECTION 504/AMERICANS WITH DISABILITIES ACT (ADA)

**Department and/or Persons Concerned:** Site Administrators, Division and Department Heads, Site 504 Coordinators, District Counselors, Nurses, Site Transportation Liaisons

**Due Date:** As necessary

**Reference:** None

**Action Requested:** Notify and distribute to site transportation liaison, school nurse, and other staff as appropriate.

**Brief Explanation:**

Students with physical or medical disabilities, **who do not have an Individualized Education Plan (IEP)**, may request transportation services under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990. Provisions for reasonable accommodations will be made for those who qualify.

**Procedure for requesting transportation under Section 504/ADA:**

1. The Section 504/ADA Request for Transportation (Attachment 1) and the Request for Transportation Verification and Recommendation (Attachment 2) forms will be available through the school nurse's office.
2. Parent will return attachment to the nurse.
3. The school nurse, following a review and assessment of all pertinent information, will complete Attachment 2.
4. The school nurse will forward Attachment 1 and Attachment 2 to the 504/ADA Office, 4100 Normal Street, Annex 6B, San Diego, CA 92103.

5. The 504/ADA Office will verify the need for transportation and notify the school nurse of the status of the request. The school nurse will inform the parent. Approved requests will be forwarded to the Transportation Department. Transportation will contact the site transportation liaison regarding the new transportation information for the student. The site transportation liaison will inform the parent of the bus stop location, date and time service begins and ends.

For additional information call Kimberly Shapazian, Program Manager, Specialized Settings, ADA/504 at (619) 725-7395.

APPROVED:



Sarah Ott

Executive Director, Special Education Division

SO:lr

Attachments (2)

SAN DIEGO UNIFIED SCHOOL DISTRICT  
504/ADA OFFICE

**REQUEST FOR TRANSPORTATION**  
**(Return Completed Form to the School Nurse)**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Service Address: \_\_\_\_\_ Does the Student Have a 504 Plan?: \_\_\_\_\_

School of Residence: \_\_\_\_\_ Does the Student Have an IEP?: \_\_\_\_\_

School of Attendance: \_\_\_\_\_ Any Special Equipment, Cast, etc.?: \_\_\_\_\_

State reason(s) for requested transportation: \_\_\_\_\_

If the reason(s) are related to your child's health, print the names and phone numbers of doctors currently managing these health conditions:

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

The above information is correct to the best of my knowledge. I permit school health staff to exchange information with my child's doctor(s). I understand that the information to be exchanged is limited to the health conditions associated with this request.

\_\_\_\_\_  
Signature of Parent/Guardian Date

.....  
(For Office Use Only)  
Section 504/ADA Decision

Denied: \_\_\_\_\_ Approved: \_\_\_\_\_ Level of Service: \_\_\_\_\_ Length of Service: \_\_\_\_\_

Comments: \_\_\_\_\_

Section 504/ADA Officer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date Transportation Notified: \_\_\_\_\_ Signature: \_\_\_\_\_

Transportation Start Date: \_\_\_\_\_ Transportation End Date: \_\_\_\_\_

Comments (Bus Stop, etc.): \_\_\_\_\_

Date School Notified: \_\_\_\_\_ Signature: \_\_\_\_\_

Date Parent Notified: \_\_\_\_\_ Signature: \_\_\_\_\_

SAN DIEGO UNIFIED SCHOOL DISTRICT  
504/ADA OFFICE

**REQUEST FOR TRANSPORTATION  
Verification and Recommendation Form**

Student Name: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_

Grade: \_\_\_\_\_ School Phone Number: \_\_\_\_\_

Student ID Number: \_\_\_\_\_ School Fax Number: \_\_\_\_\_

Case Manager: \_\_\_\_\_ School Nurse: \_\_\_\_\_

This student is recommended for transportation due to: \_\_\_\_\_

\_\_\_\_\_

Additional comments (please state if the student has extra equipment, wheelchair, cast, etc.):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does the student need to be met at the bus stop? \_\_\_\_\_

The recommended level of service is: \_\_\_\_\_  
(one block from home, one mile from home, etc.)

The recommended length of service is: \_\_\_\_\_  
(specify number of months)

Verified by: \_\_\_\_\_  
School Nurse Date

**Send completed Attachment 1 and Attachment 2 forms to:**

504/ADA Office  
Attn: Kimberly Shapazian  
4100 Normal Street, Annex 6B  
San Diego, CA 92103  
(619) 725-7395  
Fax: (619) 725-7367  
[kshapazian@sandi.net](mailto:kshapazian@sandi.net) and copy [llehmann@sandi.net](mailto:llehmann@sandi.net)