

**APPLICATION FOR ASSISTANCE WITH
TRANSPORT FOR PUPILS WITH
SPECIAL EDUCATIONAL NEEDS AND
DISABILITIES**



SECTION A: CHILD'S DETAILS

Surname:			
Forename(s):			
Date of Birth:			
Height:		Weight:	
Home Address (including postcode):			
Name of parent(s)/carer(s):			
Home phone no.		Mobile:	
Email address:			
Emergency contact: (please include name, relationship to child and phone number)			

SECTION B: SCHOOL DETAILS

Name of the school for which travel assistance is needed:										
Proposed start date: (please note, transport can take a minimum of 5 working days to set up)										
Frequency of travel: (please circle)	Daily		Weekly		Termly			52 week placement		
Please indicate times of attendance:	Mon		Tues		Weds		Thurs		Fri	
	a.m.	p.m.	a.m.	p.m.	a.m.	p.m.	a.m.	p.m.	a.m.	p.m.

SECTION C: CHILD'S NEEDS

Please tell us here about your child's special educational needs.

(Please tick appropriate boxes)

Emotional and behavioural difficulties <input type="checkbox"/>	Autistic Spectrum Disorder (ASD) <input type="checkbox"/>
Learning difficulties <input type="checkbox"/>	Hearing impairment <input type="checkbox"/>
Speech and language difficulties <input type="checkbox"/>	Epilepsy <input type="checkbox"/>
Visual impairment <input type="checkbox"/>	Physical difficulties <input type="checkbox"/>
Pathological Demand Avoidance (PDA) <input type="checkbox"/>	

Other (please specify):

Please describe below how this affects them when travelling and what action can be taken to manage these issues (e.g. listening to music, using ear defenders)

Does your child pose any risk to themselves or others? (e.g. verbal/physical/absconding risk/spitting)

Does your child have any mobility issues which will affect accessing transport?

(If YES, please provide details below)

YES

NO

Does your child use any mobility equipment? e.g. walking frame

(If YES, please provide details below)

YES

NO

Is your child a wheelchair user? (If YES, please provide further details below)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Manufacturer: Model: Powered / unpowered:		
Can your child transfer independently to a fixed seat?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does your child require specialist or additional harness? (If YES, please provide details below)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does your child travel with any medical equipment e.g. oxygen cylinder or suction? (If YES, please provide details below)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Will your child be required to travel with any medication at any time? (If YES, please provide details below)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is there anything else that affects your child when travelling to and from school that the transport provider should be aware of? e.g. travel sickness, incontinence (If YES, please provide details below)	YES <input type="checkbox"/>	NO <input type="checkbox"/>

SECTION D: TRAVEL INFORMATION

Does your child use public transport independently at weekends / out of school hours?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Has your child received Independent Travel Training?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Would you like your child to be considered for Independent Travel Training?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

SECTION E: OTHER INFORMATION

Please use this space to provide any relevant additional information you think may help the SEND Team when considering your application for Travel Assistance.

SECTION F: DECLARATION

I hereby declare that all of the information given on this form is true to the best of my knowledge and I undertake to inform the County Council immediately should any circumstances change.

Signature of parent/carer: Date:

Please return completed forms to:

Lancashire County Council, Inclusion Service, Room CH1:45, P.O. Box 78, County Hall,
Preston, Lancashire, PR1 8XB

email: Inclusion.South@lancashire.gov.uk