Child and Wheelchair Safety Concerns Checklist

Date: _____ School: _____

Student Name:

_____

Bus#: _____ Person Referring: _____

Teacher: _____ Room#: _____

Wheelchair/Student Concerns: (check all that apply)

_____Anti-tippers _____Headrest _____Head Position

_____Body Position _____Foot Rests _____Wheelchair Seat Back

_____Brakes _____Car Seat (specify) _____Bus Restraint System

_____ Book bag _____ Tie-Down Sites on s/c _____ Wheelchair Seat belt or Harness (circle)

_____ Tires (specify) _____Request visit from team to problem solve new issue or student

_____Other _____

_____

Resolutions/Recommendations

Date Form Was Received _____

_____ Repaired _____ Repair by vendor scheduled _____ Requires parental attention

_____ Other _____

_____

Instructions for Distribution

Drivers keep one copy of this form for your records. Please give original to the on-site transportation designee: _____, who should phone and/or forward the copies to the following physical therapist as soon as possible:

Therapist: _____

Base School and Phone#:_____

Additional Copies To: _____Parent _____Teacher _____Transportation