2020 – 2021

REQUEST FOR MEDICAL TRANSPORTATION

****BASED ON STUDENT'S DISABILITY****

A new application must be submitted each year

TO BE COMPLETED BY PARENT

Student's Name: _____ Student ID#:_____

Date of Birth: _____Grade: _____School: _____

Home Phone #: _____ Emergency #: _____

Home Address: _____

Transport Address: AM _____

PM _____

Parent/Legal Guardian's Name: _____

TO BE COMPLETED BY PHYSICIAN

I have examined the above-named student and have diagnosed the Student's medical/physical problem as:

_____

(In the case of asthma, please be specific regarding severity i.e., mild, moderate or severe)

The prognosis for this condition's term is: _____

It is my professional opinion that this student cannot walk <u>up to 1.5 miles</u> to school and must be provided transportation from _____ to _____.

(Date) (Date)

Please indicate the need for a wheelchair bus by checking below:

☐ **Wheelchair** ☐ **Crutches**

_____ _____

Physician's Signature Print Name

_____ _____

Physician's Address Phone #

_____ _____

Date Signed Fax #

***INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED**

Please return complete form to:

Interim Health Academy
30 Hart Street
Rochester, NY 14605
Attn: Medical Transportation Coordinator

Phone: (585) 454-1095 X4142
Fax: (585) 324-9931

Do Not Write Below This Line

	Parent	*School*	*Contractor*
	☐	☐	☐

_____

Approval Signature Date Approved Date Notified: _____

Check Box if Door 2 Door Needed ☐

Effective Date: _____

Bus Assignment: _____