



Syracuse City School District School Health Services
 725 Harrison St., Room 104
 Syracuse, New York 13210
 Phone: 435-4146 Fax: 435-4859

Rev. 10/07

Temporary Transportation for Medical Reasons

Pupil's Name: _____ Address: _____
 School: _____ Grade/Program Option: _____
 Parent/Guardian: _____ Phone: Home: _____ Work: _____ (4)

Parent or Guardian use:	<p>To be completed by parent or legal guardian:</p> <p>Do you understand a copy of an annual physical exam must accompany this request for all chronic medical conditions? Yes ____ Initial ____</p> <p>Do you understand an incomplete 3-page application will be returned and may delay your request for medical transportation? Yes ____ Initial ____</p> <p>Do you understand if curb to curb is required, that a parent/legal guardian or school personnel must be physically present at the stop? Yes ____ Initial ____</p> <p>Do you understand if no parent/legal guardian is present or a person identified to the school bus driver who is over the age of sixteen, your child may be turned over to the Syracuse Police Department Child Protective Unit, or returned to the assigned school or a designated school? Yes ____ Initial ____</p> <p>Do you understand curb-to-curb is required for any psychiatric diagnosis (including ADHD)? Yes ____ Initial ____</p> <p>Do you understand that medication and a doctor's order must be in the school nurse's office for all asthma requests? Yes ____ Initial ____ School Nurse Initial that orders in place _____. (application will not be processed without this)</p> <p>This application must be completed on an annual basis for chronic conditions and may take up to 10 days for transportation to begin.</p> <p>Parent/Guardian Signature _____ Date _____</p>
For Medical Director's Use Only:	<p>Start Date: _____ Expiration Date: _____ Winter Months Only <input type="checkbox"/> (Nov. 1st through April 15th)</p> <p>Type of Service Recommended:</p> <p><input type="checkbox"/> Unsupervised House Stop: <input type="checkbox"/> Bus Pass (only when yellow bus not available) No parent or guardian needs to be present</p> <p><input type="checkbox"/> Nearest Corner Stop: <input type="checkbox"/> Walking distances to pick-up points vary according to grade level. Grade levels K-8 will not be required to walk distances in excess of 2 blocks, and grades 9-12 will not be required to walk distances in excess of 3 blocks.</p> <p><input type="checkbox"/> Curb to Curb: <input type="checkbox"/> A curb-to-curb identified stop requires a parent or guardian to meet the child at the bus door. If there is no parent/guardian at the bus door, the child may be turned over to the school. This service is not available on dead-end streets.</p> <p><input type="checkbox"/> Wheelchair Bus: <input type="checkbox"/> Comment: _____</p>
Transportation Department Use:	<p>Winter Months Only: (November 1st through April 15th) <input type="checkbox"/></p> <p>Starting Date: _____ Expiration Date: _____</p> <p>To School: A.M. Stop _____ Time: _____ Bus # _____</p> <p>At Dismissal: P.M. Stop _____ Time: _____ Bus # _____</p>
Disposition:	<p><input type="checkbox"/> Approved <input type="checkbox"/> Disapproved _____ _____ Medical Director _____ Date _____</p>

Physician's Statement for Temporary Transportation for Medical Reasons

(to be completed on an annual basis)

To be completed by medical physician)

Student's Name _____ School _____

Reason for temporary transportation _____

Medication prescribed for diagnosis _____

Length of time requested _____ Stability of the medical condition (please circle one) Good Fair Poor

Please explain _____

Recent Physical Examination (**within one year**) must accompany this request for all chronic medical conditions. Date physical exam was done _____

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For Asthmatic conditions:

Child must have medications and doctor's order in school for emergency purposes.

What are triggering factors? _____

Are there any medical restrictions for gym class, recess or sports participation? Yes _____ No _____

Is your patient medically stable to walk 1½ miles? Yes _____ No _____ 2 blocks? Yes _____ No _____

Is the request for medical transportation absolutely **medically necessary**? Yes _____ No _____

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For Psychiatric conditions (including ADHD):

What is the medical diagnosis? _____

What medications is your patient on? _____

Is your patient emotionally stable to be attending school? _____

Does your patient require supervision at the bus stop? _____

Is your patient undergoing therapy? _____

What is the prognosis for your patient? _____

Do you have an expected date for transportation to end? _____

Physician's Signature

Printed Name

Date

**Please mail applications and copy of current physical examination to: Syracuse City School District,
Health Services, 725 Harrison St., Syracuse, NY 13210 Or Fax to 435-4859**