PINELLAS COUNTY SCHOOLS

MEDICAL REQUEST FOR SPECIAL TRANSPORTATION

*** Note: This request is only valid for one school year (August -June) ***

STUDENT INFORMATION:

Student's Name	Gender	Date of Birth	Parent/Guardian Name

Student's Address	Apt #	City	Zip

Home Telephone #	Work/Cell #	School Name	Grade

Per Pinellas County School Board policy, a parent/guardian may request consideration for special transportation for a student as a result of medical needs. The request must be completed by the student's physician, and will be reviewed and approved or denied by the Board contracted physician. **Student must be assigned to their zoned school to be eligible**.

SEC I. TO BE COMPLETED BY STUDENT'S PHYSICIAN:

Doctor's Name ______________________________

Doctor's Address ______________________________

Telephone # (727) ____________________ Fax # (727) ____________________

Student's Diagnosis: ______________________________

SEC II. BUS STOP LOCATION

1. It is my professional medical opinion that it would be in the best interest of this student to receive special transportation. Please describe how the student's medical condition impedes his/her ability to walk to school or to a normal bus stop:

   ____

   ____

   ____

2. Does the student participate in sports or PE? ____Yes ____ No (Check one)

   If yes, what are the limitations:

   ____

   ____

3. Special bus stop location: (Check one)

   ______ a. home stop - Please be aware that even if home stop is recommended, it may not be available in the following circumstances: on private property, on streets or areas where backing would be required, or on non-travelable private roads.

   ______ b. closest corner to address

4. Are there other special needs (i.e. student temporarily on crutches/wheelchair)?

   ____

5. How long will special transportation be required?

____ ____________ ______________________________________

Student's Name | Date of Birth | School

SEC III. MEDICATION

1. Last consultation date for this condition: ____________________________________
2. What medications, if any, is the patient taking? ____________________________________
3. Is medication taken only as needed? ____________________________________
4. Is medication taken daily? ____________________________________
5. Does medication need to be administered at school? ____________________________________
6. Number of office visits in the past year? ____________________________________

SEC IV. ASTHMA

1. If this request is being made because of **ASTHMA**, how do you rate the condition?

   As defined by NIH EXPERT PANEL REPORT 2: Mild _______ Moderate _______ Severe _______

2. Did student require treatment other than metered dose inhaler while at school?

   ____

________________________________ ________________________________ ____________

Please Print or Type Physician's Name | **Physician's Signature** | **Date**

TO BE COMPLETED BY PINELLAS COUNTY SCHOOLS ONLY:

Current distance from student's home to school: ____________________________________

Current distance from student's home to bus stop: ____________________________________

Request for special transportation has been:

_________ APPROVED _________ DENIED

Reason Denied:

____

____

_________ PENDING Additional Information Needed:

____

____

FOR SCHOOL USE ONLY

Student's current program:

____ 504 ____ ESE ____ General Education

I certify that this application has been reviewed by me.

____

Signature, 504 Coordinator

at ____

School name

____ ________________________

Reviewing Physician (For Special Transportation Request) | **Date**

____ ________________________

ESE Transportation Coordinator | **Date**

Forward original approved request to: ESE Transportation Coordinator