Pittsburgh Public Schools | Excellence for All

The Pathway to the Promise.™

Rev. 7/2013

TRANSPORTATION REQUEST FOR MEDICAL REASONS
PITTSBURGH PUBLIC SCHOOLS

Dear Parent or Guardian: This Information is needed by the Pittsburgh Public Schools Medical Consultant to assist in processing your request for medical transportation. Please sign the parental consent below authorizing the release of any medical information from your health care provider pertaining to this request. This information is considered confidential and shall remain in strict confidence. Return the completed form to Health Services.

NOTE: PARENT/GUARDIAN AND PHYSICIAN MUST SIGN REQUEST. MISSING SIGNATURES WILL DELAY PROCESSING.

PARENT/GUARDIAN AUTHORIZATION

Please release the requested information to the Health Services Division, Pittsburgh Public Schools.

X _____

Date **(Please Print Clearly) Parent/Guardian Name** **Parent/Guardian Signature**

TO BE COMPLETED BY PARENT/GUARDIAN **A NEW Medical Transportation Requests must be submitted each school year.**

(Please Print Clearly)

Child's Name _____ D.O.B. _____ Sex: M □ F□

School _____ Grade _____ Special Education Services YES □ NO □

If yes, what? _____

Recent Sport(s) Participation: YES □ NO □ If yes, indicate sport(s) _____

Home Address _____ ZipCode _____

Home Phone _____ Alt. Phone _____ Alt. Phone _____

Does your child receive transportation from the School District because of where you live? Yes _____ No_____
If yes, what type? School Bus _____ Van _____ or Bus Pass _____

TO BE COMPLETED BY PHYSICIAN **(Please Print Clearly)**

Date of Evaluation _____ Diagnosis _____

Nature of Disability _____

_____

Degree of Disability (indicate severity) _____

Hospitalizations / Emergency room visits related to this disability: YES □ NO □ (If yes, provide dates and reasons)

_____

_____

Medications (please list) and/or recommended interventions/devices (wheelchair, crutches, walker, etc.): _____

_____

This student is **medically disabled** and requires special transportation: YES □ NO □ **Select type of special transportation:**

Public □ School Bus □ Door-to-Door □ End Date must be provided, an extension can be requested _____

X _____

Physician Name (please print) **Physician Signature** **Phone** **Date**

! REQUEST COMPLETED BY A PA-C AND CRNP MUST ALSO BE SIGNED BY THE SUPERVISING M.D. OR D.O.

Return Request To: Health Services, Room 430, 341 S. Bellefield Avenue (15213) – or – Fax: 412-622-3927 • Office: 412-622-3940

Not Approved □ Approved For: Public □ School Bus □ Door-to-Door □ End Date _____

_____ _____ _____ _____

Medical Consultant **Date** **Health Services** **Date**

Date Request Received	Comments: