Pittsburgh Public Schools
Expect great things.

Rev.
07-2023

# PITTSBURGH PUBLIC SCHOOLS – HEALTH SERVICES
# TRANSPORTATION REQUEST FOR MEDICAL REASONS

**Dear Parent/Guardian, Physician:** A NEW Medical Transportation Request must be submitted each school year to ensure that we have current information to provide service for your child/patient. To process this request accurately, the District Physician for the Pittsburgh Public Schools requires the information below. Please sign the request authorizing the release of any medical information from your health care provider pertaining to this request ONLY. This information is considered CONFIDENTIAL and shall be treated as such. REQUEST MUST BE SIGNED. MISSING SIGNATURES WILL DELAY PROCESSING. A copy of this request may be placed in student's PPS school health file.

RETURN COMPLETED FORM TO: HEALTH SERVICES, RM. 430 – 341 S. BELLEFIELD AVE. (15213) OR FAX: 412-622-3927.
QUESTIONS, CALL 412-529-3942

Enter School Year ______

**PARENT/GUARDIAN AUTHORIZATION**

I hereby authorize my child's physician/physician's office to release medical information ONLY pertaining to this request to Health Services, Pittsburgh Public Schools.

X ______ Parent/Guardian's Name (Please Print Clearly) X ______ Parent/Guardian's Signature X ______ Date

**TO BE COMPLETED BY PARENT/GUARDIAN (Please Print Clearly)**

STUDENT'S GENDER: M ☐ F ☐ NON-BINARY ☐

| LAST NAME | FIRST NAME | DOB |
|---|---|---|
| | | |

| ADDRESS & ZIP CODE | BEST NO. |
|---|---|
| | ALT. NO. |

| SCHOOL | GR | Does your child participate in sports? Yes ☐ No ☐ If yes, list sports. |
|---|---|---|
| | | |

Does your child receive transportation from the School District because of where you live? Yes ☐ My child receives Bus Pass ☐ School Bus ☐ Van ☐
No ☐ My child is considered a walker.

| Does your child have an IEP? Yes ☐ No ☐ If yes, why? | Does your child have a 504 Plan? Yes ☐ No ☐ If yes, why? |
|---|---|
| | |

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

**! NOTE: REQUEST MUST BE CO-SIGNED BY THE COLLABORATING/SUPERVISING M.D. OR D.O. FOR MEDICAL PROFESSIONALS WITH THESE LICENSURES: MT, CNM, PA-C, DNP, CRNP OR THE REQUEST WILL BE RETURNED. REQUEST COMPLETED BY A CMA, MA, RN WILL NOT BE ACCEPTED.**

Date of Evaluation ______ Reason ______

If reason is Asthma, date of last Asthma Attack ______ PRN Medication(s) ______ List other medication(s) for Asthma ______ Date of last Pulmonary Test ______

Nature and Degree of Medical Condition for this request (indicate severity) ______

Hospitalizations / Emergency room visits related to this condition: Yes ☐ No ☐ If yes, provide date(s) and reason. Attach additional documents if necessary.

Please list medications and recommended interventions/devices for non-asthma diagnosis (wheelchair, crutches, walker, etc.): ______

If applicable, Date Student Can Attend School ______

Select recommended type: Public ☐ School Bus ☐ Door-to-Door ☐ END DATE must be provided. ______

X ______ DATE X ______ PHYSICIAN'S NAME & LICENSURE (PLEASE PRINT CLEARLY) X ______ PHYSICIAN'S SIGNATURE

PHONE NO. ______ FAX NO. ______

**! NOTE: REQUEST MUST BE CO-SIGNED BY THE COLLABORATING/SUPERVISING M.D. OR D.O. FOR MEDICAL PROFESSIONALS WITH THESE LICENSURES: MT, CNM, PA-C, DNP, CRNP OR THE REQUEST WILL BE RETURNED. REQUEST COMPLETED BY A CMA, MA, RN WILL NOT BE ACCEPTED.**

X ______ PHYSICIAN'S NAME & LICENSURE (PLEASE PRINT CLEARLY) X ______ PHYSICIAN'S SIGNATURE

## STOP - HEALTH SERVICES SECTION ONLY

TO: School Social Worker/School Counselor, At the direction of the Legal Office, Health Services is to find out if the above student has an active 504 Plan related to the reason for this request. YES ☐ or NO ☐. If yes, Please fax plan to Health Services, 412-622-3927. Your Name ______

NOT APPROVED ☐ APPROVED FOR: PUBLIC ☐ SCHOOL BUS ☐ DOOR-TO-DOOR ☐ END DATE ______

MEDICAL CONSULTANT ______ DATE ______ HEALTH SERVICES ______ DATE ______

| Date Request Received | Comments: |
|---|---|
| | |