

**PITTSBURGH PUBLIC SCHOOLS – HEALTH SERVICES** **FACE MASK OR**  
**TRANSPORTATION REQUEST FOR MEDICAL REASONS** **FACE SHIELD MUST BE WORN**

Dear Parent/Guardian and 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. To process your child's request accurately, the Medical Consultant 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 will be placed in your child'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

\_\_\_\_\_  
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** \_\_\_\_\_ **X** \_\_\_\_\_ **X** \_\_\_\_\_  
 Parent/Guardian's Name (Please Print Clearly) Parent/Guardian's Signature Date

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

<b>STUDENT'S</b>		<b>GENDER: M <input type="checkbox"/> F <input type="checkbox"/> NON-BINARY <input type="checkbox"/></b>	
LAST NAME	FIRST NAME	DOB	
ADDRESS & ZIP CODE		BEST NO.	
		ALT. NO.	
SCHOOL	GR	Does your child participate in sports? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, list sports.	
Does your child receive transportation from the School District because of where you live? Yes <input type="checkbox"/> My child receives Bus Pass <input type="checkbox"/> School Bus <input type="checkbox"/> Van <input type="checkbox"/> No <input type="checkbox"/> My child is considered a walker.			
Does your child have an IEP? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, why?		Does your child have a 504 Plan? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 \_\_\_\_\_ Diagnosis \_\_\_\_\_

If diagnosis 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.): \_\_\_\_\_

This student has a medical condition and requires medical transportation: Yes  No  If applicable, Date Student Can Attend School \_\_\_\_\_

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

**X** \_\_\_\_\_ **X** \_\_\_\_\_ **X** \_\_\_\_\_  
 DATE PHYSICIAN'S NAME & LICENSURE (PLEASE PRINT CLEARLY) 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** \_\_\_\_\_ **X** \_\_\_\_\_  
 PHYSICIAN'S NAME & LICENSURE (PLEASE PRINT CLEARLY) 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 \_\_\_\_\_

<b>MEDICAL CONSULTANT</b>	<b>DATE</b>	<b>HEALTH SERVICES</b>	<b>DATE</b>
Date Request Received	Comments:		