MEDICAL EVALUATION REQUEST

PLEASE PRINT CLEARLY IN DARK INK – ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED

STUDENT ID OR DATE OF BIRTH	**STUDENT FIRST NAME**	**STUDENT LAST NAME**

HOW LONG HAS THIS STUDENT BEEN UNDER YOUR CARE?

WHEN DID TREATMENT BEGIN FOR THE CONDITION THAT IS THE BASIS FOR THIS REQUEST?

LIST THE DIAGNOSIS OR SYMPTOMATIC INDICATORS

HOW DOES THE LIMITATION AFFECT THE STUDENT'S ABILITY TO TAKE PUBLIC TRANSPORTATION?

THIS CONDITION IS ☐ **CHRONIC** ☐ **TEMPORARY**
IF TEMPORARY, WHAT IS THE ESTIMATED DURATION? _____

HAS THERE BEEN ANY RECENT CHANGE IN THE STUDENT'S CONDITION? ☐ **NO** ☐ **YES**
If yes, please describe:

PRESENT TREATMENT TO ACCOMMODATE STUDENT'S NEEDS DURING TRANSPORTATION:

REQUESTED ACCOMMODATIONS TO ADDRESS STUDENT'S NEEDS DURING TRANSPORTATION:

☐ Stop-to-School ☐ Curb-to-School ☐ Limited Travel Time ☐ Route with Fewer Children
☐ Nurse ☐ Mini-Wagon ☐ Climate Control (A/C) ☐ Oxygen Tank Required
☐ 1:1 Paraprofessional ☐ Other: _____

PHYSICIAN'S NAME (Please print - Required)	**LICENSE # (Required)**
ADDRESS	**TELEPHONE # (Required)**
PHYSICIAN'S SIGNATURE (Required)	**DATE (Required)**

I CAN BE REACHED ON:
MON _____ ***(HRS) TUE*** _____ ***(HRS) WED***_____ ***(HRS)***

THUR _____ ***(HRS) FRI*** _____ ***(HRS)***

PLEASE SUBMIT PROMPTLY. THIS EVALUATION EXPIRES 90 DAYS AFTER PHYSICIAN'S SIGNATURE.