

## 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	s) FRI (HRS)	