Pittsburgh Public Schools
Expect great things.

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

**FACE MASK OR FACE SHIELD MUST BE WORN**

Rev. 07-2021

**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 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)

**STUDENT'S** **GENDER: M ☐ F ☐**

| 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_____ 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 type: Public ☐ School Bus ☐ Door-to-Door ☐ **END DATE must be provided. An extension can be requested.** _____

**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**_____

| MEDICAL CONSULTANT | DATE | HEALTH SERVICES | DATE |
|---|---|---|---|

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