Rockford Public School 205
Health Services Department
501 5th St
Rockford, IL 61104
815-966-5254

Request for Temporary Medical Transportation

Based on student's disability

Application must be reviewed and approved/renewed annually

To be completed by Parent

Student Name ______________________________ Student ID # ________________________

Date of Birth ___________________ Grade ___________ School ________________________

Primary Phone # _______________________ Emergency phone # _____________________

Home Address _____________________________ City/Zip _______________________________

Morning Transport Address ____

Afternoon Transport Address ____

Parent/Legal Guardian Name (Print) ____

Parent/Legal Guardian Signature ____

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For office use only - do NOT write below this line

____ ____________________________

Signature of Approver Title

Effective Dates

____________________________________ __________________________________

Start Date End Date

Family Notified: _______________________

*** Please note: Each request will be carefully reviewed using the information provided by the HealthCare Provider and the information on file at the child's school (medications, activity restrictions, participation in interscholastic sports)

BACK SIDE MUST BE COMPLETED BEFORE REQUEST IS PROCESSED

To be completed by Health Care Provider (MD, DO, APN, PA only)

I have examined _______________________ DOB _____________ on _______________

Diagnosis ____

It is my professional opinion that this student cannot walk up to 1.5 miles to school. I request that this student be provided specialized transportation for the above condition from:

______________________ to ________________________
(date) (date)

Please indicate which type of specialized transportation you recommend:

_____________________Yellow bus which stops at the corner nearest the child's home (greatest distance walked = ½ block)

_____________________ Yellow bus which stops at the child's home (child can navigate the steps of the yellow bus)

_____________________ Suburban-type vehicle which stops directly at the child's house (child cannot navigate the steps of the yellow bus)

_____________________ Child requires lift bus (child using wheelchair as primary mode of transportation

_____________________ Child requires Mini-Van type vehicle (ie: child confidently using crutches but cannot navigate the steps of a yellow bus)

_________________________________ _________________________________
HealthCare Provider Printed Name HealthCare Provider Signature

_________________________________ _________________________________
HealthCare Provider Address Phone #

_________________________________ _________________________________
Date signed Fax #

***** Incomplete applications will NOT be processed*****

Please return application form to:

Health Services Program Administrator Phone # 815-966-5254
Rockford Board of Education Fax # 815-489-2670
501 S. 7th St.
Rockford, IL 61104