ROSEVILLE AREA SCHOOLS
Transportation Adjustment Request: Medical Condition

TO BE COMPLETED BY PARENT OR GUARDIAN:

Date form completed ______________________________ School ___________________________

Student Name: ___________________________________ Birthdate: _________ Grade ________

Parent or Guardian:_____________________________Signature_________________________________

Home Phone:__________________________ Day Phone:________________________________

Home Address:___________________________________ CSZ _________________________________

Emergency Contact Name:____________________________ Emergency Contact Phone:______________

Address:____ Relationship:_________________________

TO BE COMPLETED BY PHYSICIAN

1. Student diagnosis/impairment ____

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2. Please describe conditions which aggravate the student's condition ____________________________

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3. Please indicate the distance the student can walk to school or to obtain bus service ________________

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4. Expected duration of condition ____

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5. Please indicate any other medical restrictions ____

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Physician Signature:__________________________________ Physician Phone:_____________________

FOR SCHOOL USE ONLY

Bus service level provided: ____

Start Date: ___________________________________ End Date _____________________________

Approved by Student Services: ___________________________________ Date _________________

Implemented by ____ Date __________________

CC: School Nurse, Bus Company

RETURN TO: Roseville Area Schools District Center
Transportation Department
Fax 651-635-1640

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