PITTSBURGH PUBLIC SCHOOLS – HEALTH SERVICES
TRANSPORTATION REQUEST FOR MEDICAL REASONS

Rev. 07-2024

Dear Parent/Guardian, 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/patient. To process this request accurately, the District Physician 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 may be placed in student's PPS 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

Enter 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 ☐ NON-BINARY ☐**

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 a walker.

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_____ Reason_____

If reason 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 devices for non-asthma diagnosis (i.e., wheelchair, crutches, walker, etc.): _____

_____

Only answer question if student is not attending school. Date Student Can Attend School:_____

Select recommended type: Public ☐ School Bus ☐ Door-to-Door ☐ END DATE must be provided. _____

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

NOT APPROVED ☐ APPROVED FOR: PUBLIC ☐ SCHOOL BUS ☐ DOOR-TO-DOOR ☐ END DATE_____

MEDICAL CONSULTANT _____ DATE _____ HEALTH SERVICES _____ DATE _____

Date Request Received	Comments: