



ADMINISTRATIVE REGULATION

APPROVED: August 23, 2017

REVISED: December 8, 2025

810-AR-8. TRANSPORTATION FOR MEDICAL NECESSITY

The information required below must be filled out by the Medical Doctor treating your child for the medical condition or injury that requires a medical bus to transport your child to and from school. The doctor must provide detailed information. Incomplete forms will be returned. Please submit the completed form to the school nurse. The school nurse will provide the form to the Director of Pupil Services for review. If approved, the Director of Pupil Services will forward the form to the Transportation Department. If denied, the Director of Pupil Services will provide an explanation for the denial to the parent/guardian. This form must be submitted annually.

To be filled out by the Parent/Guardian:

Student name: _____ DOB: _____

Address: _____

Name of Parent(s)/Guardian(s): _____

Phone Number to reach parent(s)/guardians: _____

To be filled out by the Doctor treating your child:

Medical Diagnosis: _____

Specific Reason requiring a medical bus: _____

Any further pertinent information (Medications, Treatments, Restrictions): _____

Length of time bus is required: _____

Doctor's Name, address, & phone number: _____

Signature of Doctor: _____ Date _____

To be completed by Director of Pupil Services:

Approved: _____ or Denied: _____

Signature of Director of Pupil Services: _____

To be filled out by the Parent/Guardian:

Application is hereby made for transportation for medical necessity for my son/daughter for medical reasons:

Name of student: _____ Age: _____

School: _____ Grade: _____ Date of Birth: _____

My child has an IEP for Special Education Services (circle one) YES or NO

Parent's Name(s): _____

Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Physician's Name: _____ Physician's Phone: _____

Physician's Address: _____

Reason for Transportation for Medical Necessity Request:

I give my permission for the Upper Darby School District to contact my child's physician to obtain any further information necessary to complete this application process, including specific diagnosis(es), plan for treatment, treatment goals, and an estimated date when transportation would no longer be necessary. Upper Darby School District may contact my child's physician while he/she is receiving Transportation for Medical Necessity in order to monitor the treatment process.

Parent/Guardian Signature: _____ Date: _____