

PINELLAS COUNTY SCHOOLS  
**MEDICAL REQUEST FOR SPECIAL TRANSPORTATION**  
\* Note: This request is only valid for one school year (August -June) \*

**STUDENT INFORMATION:**

|                   |             |               |                      |
|-------------------|-------------|---------------|----------------------|
|                   |             |               |                      |
| Student's Name    | Gender      | Date of Birth | Parent/Guardian Name |
|                   |             |               |                      |
|                   |             |               |                      |
| Student's Address | Apt #       | City          | Zip                  |
|                   |             |               |                      |
|                   |             |               |                      |
| Home Telephone #  | Work/Cell # | School Name   | Grade                |

Per Pinellas County School Board policy, a parent/guardian may request consideration for special transportation for a student as a result of medical needs. The request must be completed by the student's physician, and will be reviewed and approved or denied by the Board contracted physician. **Student must be assigned to their zoned school to be eligible.**

**SEC I. TO BE COMPLETED BY STUDENT'S PHYSICIAN:**

Doctor's Name \_\_\_\_\_

Doctor's Address \_\_\_\_\_

Telephone # (727) \_\_\_\_\_ Fax # (727) \_\_\_\_\_

**Student's Diagnosis:** \_\_\_\_\_

**SEC II. BUS STOP LOCATION**

1. It is my professional medical opinion that it would be in the best interest of this student to receive special transportation. Please describe how the student's medical condition impedes his/her ability to walk to school or to a normal bus stop:  
  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Does the student participate in sports or PE?    ☐ Yes    ☐ No    (Check one)  
If yes, what are the limitations:  
  
\_\_\_\_\_  
\_\_\_\_\_
3. Special bus stop location: (Check one)  
  
☐ a. home stop - Please be aware that even if home stop is recommended, it may not be available in the following circumstances: on private property, on streets or areas where backing would be required, or on non-travelable private roads.  
  
☐ b. closest corner to address
4. Are there other special needs (i.e. student temporarily on crutches/wheelchair)?  
  
\_\_\_\_\_
5. How long will special transportation be required?

Student's Name

Date of Birth

School

**SEC III. MEDICATION**

1. Last consultation date for this condition: \_\_\_\_\_
2. What medications, if any, is the patient taking? \_\_\_\_\_
3. Is medication taken only as needed? \_\_\_\_\_
4. Is medication taken daily? \_\_\_\_\_
5. Does medication need to be administered at school? \_\_\_\_\_
6. Number of office visits in the past year? \_\_\_\_\_

**SEC IV. ASTHMA**

1. If this request is being made because of **ASTHMA**, how do you rate the condition?  
As defined by NIH EXPERT PANEL REPORT 2: Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_
2. Did student require treatment other than metered dose inhaler while at school?  
\_\_\_\_\_

\_\_\_\_\_  
Please Print or Type Physician's Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

**TO BE COMPLETED BY PINELLAS COUNTY SCHOOLS ONLY:**

Current distance from student's home to school: \_\_\_\_\_

Current distance from student's home to bus stop: \_\_\_\_\_

Request for special transportation has been:

\_\_\_\_\_ APPROVED \_\_\_\_\_ DENIED

Reason Denied:

**FOR SCHOOL USE ONLY**

Student's current program:

\_\_\_\_ 504 \_\_\_\_ ESE \_\_\_\_ General Education

I certify that this application has been reviewed by me.

\_\_\_\_\_  
Signature, 504 Coordinator

at \_\_\_\_\_  
School name

\_\_\_\_\_  
Reviewing Physician (For Special Transportation Request)

\_\_\_\_\_  
Date

\_\_\_\_\_  
ESE Transportation Coordinator

\_\_\_\_\_  
Date

Forward original approved request to: ESE Transportation Coordinator