LEVITTOWN PUBLIC SCHOOLS

Levittown Memorial Education Center
150 Abbey Lane
Levittown, New York 11756

REQUEST FOR SPECIAL TRANSPORTATION (HEALTH PLAN)

SCHOOL YEAR ___________________

NAME _____________________________________ D.O.B. ______________________________

ADDRESS _________________________________ PHONE ______________________________

SCHOOL __________________________________ GRADE ______________________________

CURRENT BUS STOP____

STUDENT IS **NOT** CURRENTLY ON A BUS AND NEEDS BUS SERVICE: **Yes or NO**

TRANSPORTATION IS NEEDED: TO And FROM Home to School **Yes or No**
(circle yes or no) TO and FROM GC TECH **Yes or No**

I. FAMILY PHYSICIAN:
Health transportation is required for the above-named student for the following reasons:

a. Medical Diagnosis:____

b. DATES TRANSPORTATION IS NEEDED: From: ___________________ to _________________

c. TYPE OF BUS: **Mini**______________ **Full Size** _________________ **Wheelchair**_____________

d. DOOR TO DOOR ___________or CURRENT BUS STOP (Corner)____________ (Check one)

Comments:____
____
____

_______________________________ _______________________________
Physician's Stamp Physician's Signature/Date

II. SCHOOL NURSE:

1. This student has received special/health transportation in the past _____yes _______no.

2. The student has a health plan on file with the school nurse ______yes ______no.

____
School Nurse's Signature/Date

III. RECOMMENDATION OF SCHOOL PHYSICIAN

1. **APPROVE/DENY** the above transportation request. Denied requests go to the Administration Dept. and they will then forward a letter to the child's parents with the denied request. Approved requests are returned to the Transportation Dept.

____
School Physician's Signature/Date

IV. TRANSPORTATION OFFICE

Approved_____________________ Denied___________________

Reason for Denial

____

____

____
Transportation Supervisor's Signature/Date