



LEVITTOWN PUBLIC SCHOOLS
Levittown Memorial Education Center
150 Abbey Lane
Levittown, New York 11756



REQUEST FOR TEMPORARY MEDICAL TRANSPORTATION
SCHOOL YEAR _____

NAME _____ D.O.B. _____

ADDRESS _____ PHONE _____

SCHOOL _____ GRADE _____

CURRENT BUS STOP _____

STUDENT IS **NOT** CURRENTLY ON A BUS AND NEEDS TEMPORARY 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. Treatment given/Specialist _____

c. Is the child wearing a **CAST, SLING, BOOT, is ON CRUTCHES OR IN A WHEELCHAIR?**

d. DATES TRANSPORTATION IS NEEDED: From: _____ to _____

e. TYPE OF BUS: **Mini** _____ **Full Size** _____

f. DOOR TO DOOR _____ or CURRENT BUS STOP (Corner) _____ (Check one)

g. Are there any restrictions on Physical Educational Activities? _____ yes _____ no.

GC TECH Students: Can student participate in hands on classroom activities? Y or N

Comments: _____

Physician's Stamp

Physician's Signature/Date

II. SCHOOL NURSE:

1. This student has received medical transportation in the past ____yes ____no.

2. During the current/prior school year the above-named student has been absent for medical reasons _____(##) days.

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