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 (BOCES) **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

- School Nurse, please email form to: Dr. Kowal-Connelly.

III. RECOMMENDATION OF SCHOOL PHYSICIAN

1. **APPROVE/DENY** the above transportation request. If further information is needed please comment below.

   Comments:

   _____
   _____

   _____
   School Physician's Signature/Date

- School Dr. is to return signed form to the school nurse it was received from.

Received on _____ by School Nurse.
Send approved requests to Transportation.
Send letter to parents for denied requests.

IV. TRANSPORTATION OFFICE

Approved_____ Denied_____

Reason for Denial

_____

_____

_____
Transportation Supervisor's Signature/Date