LEVITTOWN SCHOOL DISTRICT
REQUEST FOR MEDICAL TRANSPORTATION FOR SCHOOL YEAR _____

OFFICE USE ONLY

NAME_____D.O.B._____ RTE AM__PM__

ADDRESS_____PHONE_____ TIME:_____

SCHOOL_____GRADE_____ STOP:_____

I. FAMILY PHYSICIAN:
Health transportation is required for the above-named student for the following reasons: (Give medical diagnosis)._____

_____

Treatment /plus medication given:_____

_____

Name of Specialist, (if any):_____

Transportation is requested for the following duration:_____

_____ _____
Physician 's Stamp Physician 's Signature/Date

II. SCHOOL NURSE:
1. This student has in the past received medical transportation_____yes_____no
2. During the prior school year the above-named student has been absent for m edical reasons, _____days.
3. Are there any restrictions on Physical Educational Activities?_____yes_____no
4. Comments:_____

_____
School Nurse's Signature/Date

III. RECOMMENDATION OF SCHOOL PHYSICIAN
1. Approve/disapprove the above transportation request and recommend that the Levittown Committee on Special Education approve/disapprove same.

IV. YOU WILL BE NOTIFIED AS SOON AS YOUR APPLICATION HAS BEEN PROCESSED
Transportation is: Approved_____Denied_____