## THE SCHOOL DISTRICT OF PHILADELPHIA SCHOOL HEALTH SERVICES

## **MEDICAL TRANSPORTATION REQUEST - PHYSICIAN CERTIFICATION**

Student's Name		Student I.D.	Date of Birth	
Но	ome Address			
Sch	hool	Location No.	Region	
	TO BE COMPLETED BY THE STUDENT'S PHYSICIAN AND RETURNED TO			
	Inc	SCHOOL NURSE		
	The above student is requesting transpo	portation to and from school by t	the School District of Philadelphia	
	medical reasons. This request is under consessment with the following information:			
1.	Diagnosis			
2.	Date of onset			
3.	Medical reason(s) student cannot walk or take public transit to and from school:			
4.	When do you expect the student to be able to get to and from school without transportation services?			
5.	The student will be picked up and dropped off at a designated school bus stop unless this is contraindicate Please give medical reasons student cannot be picked up and dropped off at a designated bus stop:			
Name of Physician (PRINT)		Signature of Physician	Date	
Address		Pf	hone	