THE SCHOOL DISTRICT OF PHILADELPHIA

SCHOOL HEALTH SERVICES

MEDICAL TRANSPORTATION REQUEST - PHYSICIAN CERTIFICATION

Student's Name	Student I.D.	Date of Birth
Home Address		
School	Location No.	Region

TO BE COMPLETED BY THE STUDENT'S PHYSICIAN AND RETURNED TO THE SCHOOL NURSE

The above student is requesting transportation to and from school by the School District of Philadelphia for medical reasons. This request is under consideration. Please document in detail the medical justification for the same 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 contraindicated. 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	Phone	