VERNON PUBLIC SCHOOLS

30 Park Street • P.O. Box 600
Vernon, CT 06066-0600
Tel: 860-870-6000
SCHOOLTRANSPORTATION@VERNON-CT.GOV

REQUEST FOR MEDICAL TRANSPORTATION

SECTION I (To be completed by parent/guardian):

STUDENT NAME: _____ SCHOOL: _____ GRADE: _____

HOME ADDRESS: _____

PARENT/GUARDIAN: _____ CONTACT NUMBER: _____

SECTION II (To be completed by Physician ONLY)

IS STUDENT ABLE TO WALK A MEASURABLE DISTANCE TO A BUS STOP OR SCHOOL? ☐ YES ☐ NO

IF YES, DISTANCE STUDENT IS ABLE TO WALK TO BUS STOP/SCHOOL: _____
(Please be as specific as possible, for example, 300 feet, ¼ mile etc.)

REQUESTED METHOD OF TRANSPORTATION: ☐ REGULAR BUS ☐ MINI BUS ☐ LIFT BUS

OTHER LIMITATIONS: (For example, physical education, school sports, recess, etc.): _____

_____

SPECIAL EQUIPMENT REQUIRED (For example, crutches, immobilizer, etc.):_____

_____

HOW LONG WILL THIS SERVICE BE NEEDED: START DATE: _____ END DATE: _____

IS DIAGNOSIS TRIGGERED BY COLD AIR? ☐YES ☐NO

TREATING PHYSICAN NAME: _____EXAMINATION DATE: _____

PHONE NUMBER: _____ FAX NUMBER: _____

As the physician treating the above patient, I certify that the transportation being requested is medically required. I understand that the transportation being requested is valid only for the school year in which the request is made and if this transportation will be required in subsequent school years, I will need to provide a new request.

SIGNED: _____

THIS FORM MUST BE FAXED OR E-MAILED DIRECTLY FROM THE PHYSICIAN'S OFFICE.
FAX: 860-870-6008 SCHOOLTRANSPORTATION@VERNON-CT.GOV