THE SCHOOL DISTRICT OF PHILADELPHIA SCHOOL HEALTH SERVICES

MEDICAL TRANSPORTATION REQUEST - PHYSICIAN CERTIFICATION

Student's Name		Student I.D.	Date of Birth	
Но	me Address			
Sc	hool	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	When do you expect the student to be able to get to and from school without transportation services?		
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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:			
Na	me of Physician (PRINT)	Signature of Physician	Date	
Ad	dress	Ph	none	
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