Transportation Department
835 Hudson Ave. Rochester, NY 14621
Phone: (585) 336-4000 Fax: (585) 336-4193

2025 - 2026

REQUEST FOR MEDICAL TRANSPORTATION

****BASED ON STUDENT'S DISABILITY****

A new application must be submitted each year

TO BE COMPLETED BY PARENT

Student's Name: _____ Student ID#: _____
Date of Birth: _____Grade_____ School: _____
Home Phone #: _____ Emergency #: _____
Home Address: _____
Transport Address: AM _____
PM _____
Parent/Legal Guardian's Name: _____

TO BE COMPLETED BY PHYSICIAN

I have examined the above-named student and have diagnosed the Student's medical/physical problem as:

_____
(In the case of asthma, please be specific regarding severity i.e., mild, moderate or severe)

The prognosis for this condition's term is: _____

It is my professional opinion that this student cannot walk <u>up to 1.5 miles</u> to school and must be provided transportation from _____ (date) to _____ (date).

Please indicate the need for a wheelchair bus by checking: Wheelchair _____

_____ _____
Physician's Signature **Print Name**

_____ _____
Physician's Address **Phone #**

_____ _____
Date Signed **Fax #**

***INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.**
***A MEDICAL EXCEPTION DOES NOT GUARANTEE DOOR TO DOOR TRANSPORTATION. EVERY EFFORT WILL BE MADE TO MEET THE NECESSARY REQUIREMENTS BASED ON INDIVIDUAL NEEDS.**

*****Note:** ADHD or emotional concerns **do not qualify** for medical transportation through this department. These must be submitted to the **Department of Special Education**.

Return completed form to:
Medical Transportation Coordinator Fax: (585) 324-9931 Phone: (585) 254-1240 ext. 3432

FOR NURSE & TRANSPORTATION COORDINATOR USE ONLY

☐ **Approved** ☐ **Denied** **Reason for Denial / Notes:** _____
Nurse:_____ **Date:**_____ **Transportation:**_____ **Date:**_____
Effective Date: _____ **Bus Assignment #:** _____ **Date Parent Notified:** _____