Transportation Department
transportationrequests@rcsdk12.org
Phone: (585) 336-4000 Fax: (585) 336-4193

2024 – 2025

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_____ ID #_____ Grade _____
Home Address _____ Zip Code _____ Home # _____
School _____ Emergency # _____
Transport Address: AM _____
PM _____
Parent/Guardian's Name ____ _____ Student's Date of Birth _____

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 up to 1.5 miles to school and must be provided transportation from _____ to _____.
(date) (date)

_____ _____
Physician's Signature Print Name

_____ _____
Physician's Address Phone #

_____ _____
Date Signed Fax #

Please return completed form to:

Interim Health Academy Phone: (585) 454-1095 Option 3
30 Hart St
Rochester, NY 14605 Fax: (585) 324-9931
Attn: Medial Transportation Coordinator

***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.**

_____	_____	_____	_____	_____
Approval Signature	**Date Approved**	**Date Notified**	**Effective Date**	**Bus Assignment**