SYRACUSE CITY SCHOOL DISTRICT
Pamela J. Odom, Superintendent of Schools

Health Services

Transportation for Medical Reasons Application

Dear Parent/Guardian:

Please read the information carefully and note the following:
Medical Transportation is for a short time only. Even if your doctor fills out the form, this does not mean that your student will automatically get transportation. If your student has a condition that requires medical transportation, they may also be restricted from other school activities, such as physical education and sports. Should application(s) for medical transportation exceed a six-month period, the District may refer the student for evaluation by the Section 504 Committee or the Committee on Special Education, whichever is appropriate.

Requests for medical transportation will be granted for students who are unable to ride a standard school bus or who are unable to walk the distance between their home and school. Examples of reasons for medical transportation may include the following, **if** they prevent a student from reasonably accessing school:

- A student who uses a wheelchair, crutches, or a walker
- A student who is unable to walk more than 50 feet due to a debilitating cardiopulmonary or neuromuscular condition
- A student with **severe** asthma, a heart condition, or another medical condition that can cause significant fatigue when walking distances from home to school (these students will need a letter of justification from a pulmonologist, cardiologist, or other specialist)
- A student with autism, mental illness, or an intellectual disability who cannot ride a traditional bus safely (temporary transportation provided only until evaluation by CSE)
- A student on oxygen or a ventilator

A physical exam completed within the last 12 months MUST be submitted with the application or application will not be processed.

For students with **asthma, allergies, or seizures,** doctor's orders for medications to be given in school and an appropriate action plan must be sent in with the transportation form. Once school starts, your student's medicine **must** be brought to school **by an adult.**

Curb-to-Curb will be determined on a case-by-case basis. If your student has curb-to-curb medical transportation, this means that a parent or guardian **MUST MEET** the bus for pick-up in the morning, and drop-off in the afternoon/evening.

If the application is approved, transportation may take up to 15 days to begin. If your student qualifies for medical transportation, a letter will be sent home with your student FROM THE OFFICE OF THE SCHOOL THEY ATTEND. If they do NOT qualify, you will receive a letter from Health Services.

Please give the completed application form and a copy of your student's current physical examination to your student's school nurse, or send/fax to the address on the bottom of this application. Incomplete applications will be returned and will delay the approval process. Thank you for your assistance regarding this matter.

Sincerely,

Ted J. Triana, D.O.
Medical Director

SYRACUSE CITY SCHOOL DISTRICT

Pamela J. Odom, Superintendent of Schools

Transportation for Medical Reasons

Student Name _____ School _____

Address _____ Grade _____ Date Approved _____

Parent/Guardian _____ Phone 1: _____ Phone 2: _____

Parent or Guardian Use	**This section to be completed and signed by parent/guardian. Please read the following carefully and sign to confirm that you understand the following:** • I understand that the District may use the information submitted with this request to evaluate whether my student may safely participate in sports and/or physical education • I understand that a copy of the student's physical exam must accompany this request for all medical conditions • I understand that if my student will be participating in athletics this year, they may not be eligible for medical transportation. • I understand that an incomplete application will be returned and may delay my request • I understand that if curb-to-curb is required, a parent/guardian must be physically present at the stop • I understand that prescribed medication and a doctor's order must be in the school nurse's office for all asthma/seizure/allergy requests • I understand if no parent/guardian is present, or a person identified to the bus driver who is over the age of 16, my student may be turned over to the Syracuse Police Department Child Protective Unit, or returned to their assigned school or a designated school Once the application is received, it may take up to 15 days for transportation to begin, if approved. **Does your child have an IEP or a 504 Plan?** ☐ **IEP** ☐ **504 Plan** ☐ **No** **Parent/Guardian Signature** _____ **Date** _____
For SCSD Medical Director's Use Only	Start Date _____ Expiration Date _____ ☐ Winter Months Only (Nov 1st – Apr 15th) Type of Service Recommended: ☐ **Unsupervised House Stop:** No parent/guardian needs to be present ☐ **Nearest Corner Stop:** Walking distances to pick-up points vary by grade level. Students will not be required to walk more than 2 blocks in Grades K-8, or 3 blocks in Grades 9-12 ☐ **Curb-to-Curb:** A curb-to-curb stop requires an adult meet the student at the bus door. This service is **not available** unless a bus may safely navigate the street of residence. ☐ **Wheelchair Bus** **Comment** _____
Disposition	☐ **Temporary** ☐ **Permanent** ☐ **Denied** _____ _____ _____ SCSD Medical Director or Designee Date

Please send completed application and a copy of your student's current physical examination to your student's School Nurse or SCSD Health Services at the address or fax below. Incomplete application will delay the approval process.

SYRACUSE CITY SCHOOL DISTRICT

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO SCHOOLS

Please sign this so that we may get health information from your child's doctor.

Student Name: _____ DOB: _____ Date: _____

As the parent/guardian of the student named, the completion of this form authorizes your doctor to disclose your student's confidential health-related information to his or her school.
The purpose for disclosing this information is to promote the accurate exchange of health information and for the coordination of care and treatment with the student's school. This is important information for many reasons. For example, the school may need to know this information to give medications, monitor the student's illness, and keep track of immunizations.

Provider/Practice Name: _____

Address: _____ Phone Number: _____

This authorization limits the disclosure of information to the following:

- ☐ Immunization Information
- ☐ Physical Exam Reports
- ☐ Laboratory Tests
- ☐ Medications and Treatments

This authorization form does not allow the disclosure of confidential health information that is given special protection under the law. This includes HIV-related information, substance abuse information, psychiatric information and genetic information; the disclosure of this information requires a different specific form.
The information will be disclosed to the school in the school district indicated below until you tell us that the student is no longer an enrolled student at the school. You may revoke this authorization at any time by notifying the student's healthcare provider in writing. Revoking this authorization means that we will no longer disclose the student's information to their school. The students' healthcare will not be affected if you do not authorize us to disclose their information to the school. In other words, we will not refuse your student treatment if you do not sign this authorization. The information we disclose to the school may be redisclosed to others by the school if the school is not required under law to protect the confidentiality of this information. Please keep a copy for your records.

_____ _____

Student's Name (print) Date of Birth

_____ _____

Parent/Guardian's Name (print) Relationship

_____ _____

Parent/Guardian's Signature School

PLEASE RETURN TO THE SCHOOL NURSE

SYRACUSE CITY SCHOOL DISTRICT

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PROVIDER'S STATEMENT for Transportation for Medical Reasons

(To be completed by medical provider)

Student Name _____ School _____

Date last physical exam completed: _____ A physical examination (within one year) **must be attached.**

For Asthmatic Conditions:

☐ **Stable** **or** ☐ **Unstable** **If unstable,** ☐ **Moderate** **or** ☐ **Severe** ☐ **Winter Months Only**

Please explain: _____

What medication(s) is your patient on? _____

What are triggering factors? _____

Are there any medical restrictions for gym class, recess, or sports? ☐ **No** ☐ **Yes** _____

Please note: medical transportation for students may also result in the student being restriction from physical education and sports. Please discuss this with the parent/guardian.

For Psychiatric Conditions (including ADHD):

What is the diagnosis? _____

What medication(s) is your patient on? _____

Is your patient undergoing therapy? ☐ **Yes** ☐ **No** If no, why not? _____

Name of Mental Health Provider: _____

Does your patient require supervision at the bus stop? ☐ **Yes** ☐ **No**

If no, please explain why the student needs medical transportation: _____

For Other Conditions:

Your student **MUST** have, if applicable, medications, provider's orders, and an appropriate action plan (seizure, allergy, diabetes) in school for emergency purposes.

Diagnosis/Reason for Transportation: _____

Medication(s) prescribed for diagnosis: _____

_____	_____	_____
Provider's Signature	**Provider's Stamp (REQUIRED)**	**Date**

Please send completed application and a copy of your student's current physical examination to your student's School Nurse or SCSD Health Services at the address or fax below. Incomplete application will delay the approval process.

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SCHOOL NURSE STATEMENT for Transportation for Medical Reasons

(This section to be completed by the School Nurse **ONLY**)

Student Name: _____ DOB: _____

Does the student currently participate in physical education and/or school sports?
How frequently does the student require attention for asthma exacerbations?
Does the student have non-expired medication in place at school? ☐ **Yes** ☐ **No**
Does the student have a current medical provider's order in place for their medication in school? ☐ **Yes** ☐ **No**
Please state any information relevant to the student's medical history that will affect them receiving transportation:

Nurse's Signature: _____ Print Name: _____

School: _____ Phone Number: _____