SEATTLE PUBLIC SCHOOLS
APPLICATION FOR MEDICAL TRANSPORTATION

ID: _____ School: _____ Grade: _____

Name of Student: _____ _____
(Last) (First) (Middle Initial) (Birthdate)

Parent/Guardian's Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Nature of Need: _____

_____

_____ _____
(Parent/Guardian's Signature) (Date)

APPLICATION MUST BE RENEWED EACH YEAR OR BEFORE TERMINATION DATE IF THERE IS A CONTINUING NEED.

To be Completed by Health Care Provider

Diagnosis: _____

_____

Recommendation: _____

_____

Number of blocks student can walk to bus: _____ Duration of transportation need: _____

_____
(Signature of Health Care Provider)

_____
(Printed Name of Health Care Provider)

_____
(Address)

_____
(Phone)

Return Application To:

Student Health Services
P.O. Box 34165, MS 31-650
2445 Third Avenue South
Seattle, Washington 98124-1165

(206) 252-0751 - fax

_____
(Date)

---------- OFFICE USE ONLY ----------

This student **G** is approved **G** is not approved for medical transportation to and from school because of a medical need.

Beginning date: _____ Ending date: _____

Reviewed by: _____ Date: _____

:jb:wp:11/26/02:transp.001