

**LOCKPORT CITY SCHOOL DISTRICT
APPLICATION FOR STUDENT TRANSPORTATION
BASED ON MEDICAL OR PHYSICAL LIMITATION**

TO BE COMPLETED BY THE PARENT/GUARDIAN:

Attending Physician: _____ Date: _____

Student's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

School: _____ Dismissal Time: _____

Name of Parent/Guardian: _____

Address (if different from above): _____ Phone: _____

I hereby grant permission for the medical staff of the Lockport City School District to obtain medical information from the ordering physician in order to evaluate the need for special transportation.

(Signature of parent/guardian)

(Date)

TO BE COMPLETED BY THE PHYSICIAN AND RETURNED TO:

Amanda Bennett, Director of Student Services
130 Beattie Avenue
Lockport, NY 14094
716-478-4623
Fax: 716-478-4814
abennett@lockportschools.net

Please note: all applications are reviewed every 30 days.

DIAGNOSIS:

Date of Onset of Condition: _____ Starting date of transportation: _____ Length of time needed: _____

If diagnosis is asthma, please complete this section:

Date of Onset: _____ Current Medications: _____

Has the student had consultation with the allergist? _____ Has the student had pulmonary function tests?: _____

Is Asthma exercise induced? _____ Weather induced? _____

Starting date of transportation: _____ Length of time needed: _____

(Physician's Signature) (Date)

OFFICE STAMP:

__Approved

__Denied

(School Physician/NP)

(Date)

COMMENTS: _____

FOR TRANSPORTATION OFFICE USE ONLY:

Arranged with: _____ at Ridge Road Express on _____
(date)

Approximate starting date: _____

6/22 HS:ab