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:

Sheila Murphy, Director of Student Services
319 West Avenue
Lockport, NY 14094
716-478-4623
Fax 716-478-4634
smurphy@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: _____

_____ OFFICE STAMP:

(Physician's Signature) (Date)

__Approved __Denied _____ _____

(School Physician/NP) (Date)

COMMENTS: _____

FOR TRANSPORTATION OFFICE USE ONLY:

Arranged with: _____at Ridge Road Express on _____

(date)

Approximate starting date: _____ 8/1/18 LMS