CLEVELAND METROPOLITAN SCHOOL DISTRICT
Vision to Victory

MEDICAL REQUEST FOR TRANSPORTATION

The Parent or Guardian of _____, _____
(Student Name) (Student ID Number or Birthdate)

who resides at _____, _____
(Address, Zip) (Telephone Number)

is requesting special transportation consideration for his/her child to _____
(School Name)

ALL INFORMATION RECEIVED WILL BE KEPT CONFIDENTIAL

In your professional opinion, does this student suffer from any condition that would physically prohibit his/her walking to school thus requiring transportation? **Yes** ☐ **No** ☐

(Transportation requirements: two miles – elementary, two miles- middle school and three miles – high school.)

A physician must attach a detailed statement of medical diagnoses, medication, duration, and any other supporting evidence why special transportation is necessary for the student. CMSD policy requires a physical to be completed on all students each year; please include a physical with this report. Include information on how walking to school aggravates the student's condition.

Physician Name: _____ Telephone: _____

Address: _____ Date: _____

Physician Stamp: _____

_____

RELEASE OF INFORMATION: I hereby authorize the Medical/Mental Health Professional named above to release the requested information to the Cleveland Municipal School District. I further authorize the District to submit this information to the District's Health Services Office. A copy of this authorization is as valid as the original. Such information may also become a part of the student's school health record.

_____ _____
Signature of Parent/Guardian Date

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APPROVED	DENIED
☐	☐

_____ _____
Evaluator's Signature Date

TRANSPORTATION INFORMATION									
BEGIN DATE:			END DATE:			CODE:	SCHOOL BUS	RTA	CAB
							☐	☐	☐

RETURN TO: (Before September 1st): Health Services, 1671 East 71st Street, Cleveland, Ohio 44103
Phone: 216-361-8142 Fax: 216-361-8122

(After September 1st): Return to your School Nurse