LAWRENCE PUBLIC SCHOOLS
LAWRENCE MASSACHUSETTS

REQUEST FOR MEDICAL TRANSPORTATION

TODAY'S DATE: ____________________ STUDENT ID #: ____

STUDENT D.O.B.: _________________________ NEW RESTART CHANGE

NAME OF STUDENT: ____

STUDENT ADDRESS: ____

STUDENT HOME PHONE: __________________________ SCHOOL: ____________ GRADE: __________

NAME OF PARENT OR GUARDIAN: ____

RELATIONSHIP: ___________________________________ EMERGENCY PHONE: ___________________

PHYSICIAN NAME: ____

ADDRESS: ____

PHYSICAIAN TELEPHONE: ____________________________

DIAGNOSIS: ____

NATURE OF PHYSICAL DISABILITY (please describe why is this student is unable to walk to school)

____

____

TRANSPORATION REQUIREMENTS: (PLEASE CHECK APPROPRIATE AREA)

1. SCHOOL BUS (Pick up/drop off at nearest school bus stop)
2. MINI SCHOOL BUS (curb to curb service)
3. WHEEL CHAIR SCHOOL BUS (curb to curb service)
4. OTHER: (please describe) ____

TIME PERIOD TRANSPORATION WILL BE NEEDED: (Please check appropriate Area)

1. One to three months
2. Winter months only (Thanksgiving Day to April 15)
3. Entire School Year

PHYSICIAN'S SIGNATURE: ____ DATE: ____________

Please return this request to: Transportation Supervisor
Lawrence Public School
P.O Box 1498
Lawrence MA 01842

Approved: ________ Date: ________ Disapproved: _______ Date: __________

Rev. 06/2014 Form T-2