DAYTON PUBLIC SCHOOLS

TRANSPORTATION REQUEST FOR STUDENTS WITH MEDICAL CONCERNS

Date of Referral:_____

Student's Name:_____**Date of Birth:**_____

Parent/Guardian Name:_____

Street Address:_____**State:**_____

School Attending:_____

Reason for Referral:_____

Parent/Guardian's Signature:_____

To The Examining Physician: (Please Print)

The above-named parent has indicated that this child is in need of special transportation services for a pre-existing medical condition. Please complete the following:

Diagnosis/Degree of Severity:_____

Is the student so disabled that they are unable to walk to and from school? (Not to exceed 1.5 miles)____Yes____No

Is the student capable of walking up to ½ mile to a bus stop?_____Yes ____No

If the student has asthma, does the student use a rescue inhaler? _____Yes _____No

If yes, how often:_____ **Will the student be required to have an inhaler at school ___Yes ___No**

Do you recommend special transportation? ____Yes ____No Please indicate period of time:_____

Physician's Name:_____**Phone:**_____

Office Address:_____

Physician's Signature:_____

Director of Health Services, Virginia Noe—Comments: _____

***Please Mail Form to*:** **Dayton Public Schools, 115 S. Ludlow St., Att: Health Services, Dayton, Ohio 45402 or**
Fax Form to: (937) 542-3391 Phone: (937) 542-3405

OFFICE USE ONLY

Type of Conveyance: RTA_____Taxi _____ Special Needs _____ Other_____

_____	_____	_____	_____
Bus Stop	**Route#**	**Bus#**	**Pick Up Time**

_____ _____

Starting Date of Transportation **Date Card Completed and by Whom**