MEDICAL REQUEST FOR TRANSPORTATION
CLEVELAND MUNICIPAL SCHOOL DISTRICT

The Parent or Guardian of _____ _____ who
Student Name Student I.D Number or **B**irthdate

resides at _____, _____ is
Address Telephone Number

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 Medical Review 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

Approved ☐ Denied ☐ Evaluators Signature: _____ Date: _____

TRANSPORTATION – begin date: _____ end date: _____

TRANSPORTATION CODE: _____ School Bus ☐ RTA ☐ Cab ☐

RETURN TO: (Before September 1st): Health Services, 1440 Lakeside Avenue, Cleveland, Ohio 44114
Phone: 216-523-7971 Fax: 216-592-7399

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