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: _____ PHONE: _____

ADDRESS: _____

DIAGNOSIS: _____

NATURE OF PHYSICAL DISABILITY (please describe why is this student 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 Department
Lawrence Public Schools
P.O Box 1498
Lawrence MA 01842

Approved: ☐ Date:_____ Disapproved: ☐ Date: _____