

**REGIONAL SCHOOL CHOICE OFFICE
MEDICAL TRANSPORTATION REQUEST FORM
SCHOOL YEAR 2016-2017**

Initial Change Request Ticket #: _____ (Office Use Only)

This section to be completed by parent/guardian.

Student's Last Name

First Name

Date of Birth (M/D/Y)

Student's street address

City/Town

Zip Code

Parent/Legal Guardian's Name

Home Phone Number

Cell Phone Number

School Attending in 2016-17

Entering Grade in 2016-17

Please respond to the following questions:

1. Does your child have a Special Education IEP? ___Yes ___No
If YES, does that IEP require transportation services? ___Yes ___No
If YES, please attach a copy of the IEP to this form.

2. Does the child have a Section 504 plan? ___Yes ___No
If YES, does that Section 504 Plan require transportation services? ___Yes ___No
If YES, please provide a copy of the student's Section 504 Plan?

Parent/Legal Guardian's Signature

Today's Date

This section is to be completed by the student's doctor.

1. Please describe the student's medical condition, which would require a closer bus stop for his/her school bus.

2. In what way (s) does this medical condition limit the student's ability to access school bus transportation?

3. When did the student begin treatment for this medical condition?
Date: _____

4. What is the actual or expected date the student's treatment for this medical condition will cease and special transportation will no longer be required? Date: _____/_____/_____

Physician's Name (please print)

Physician's telephone number

Physician's signature

Today's Date

Physician's office must fax this to: Attn: RSCO/CREC TRANSPORTATION, Fax #860-524-4005

*****Forms submitted by parents/guardians will not be accepted*****