SYRACUSE CITY SCHOOL DISTRICT
Health Services
Jaime Alicea, Superintendent of Schools

TEMPORARY Transportation for Medical Reasons

Dear Parent/Guardian:

In order to provide better services to our students, we have included information that will help in completing the application process**. Please read the information carefully and note the following:**

Temporary transportation is for a short time only. Even if your doctor fills out the form it does not mean that your child will automatically get transportation.

A physical exam **completed within the last 12 months** must be submitted with the application.

For children with **asthma, allergies, or seizures**, doctor's orders for medicines to be given in school and an appropriate action plan must be sent in with the transportation form. Once school starts, your child's medicine **must** be brought to school. If medicine is not received by the school nurse, transportation may be stopped.

According to our practice, curb–to–curb is necessary for ***any*** mental illness. This means that a parent or guardian must **meet the student at the bus door**.

The application takes time to review and, if approved, it may take up to **10 days** for transportation to start.

Please send completed application and a copy of your child's current physical examination to: Syracuse City School District, Health Services, 725 Harrison St., Syracuse, NY 13210 or fax to 315-435-4859. Incomplete applications will be returned and will delay the approval process.

Thank you for your assistance regarding this matter.

Sincerely,

Ted J. Triana, D.O.
Medical Director

TT/sk

SYRACUSE CITY SCHOOL DISTRICT
Health Services
Jaime Alicea, Superintendent of Schools

TEMPORARY TRANSPORTATION FOR MEDICAL REASONS

Pupil's Name _____ Address_____

School _____ Grade _____

Parent/Guardian _____ Phone: Home _____Work _____

Parent or Guardian use	**To be completed by parent or legal guardian:** I understand that a copy of an annual physical exam must accompany this request for all medical conditions. Yes _____ Initial _____ I understand that an incomplete application will be returned and may delay your request for medical transportation. Yes _____ Initial _____ I understand that if curb-to-curb is required, a parent/legal guardian or school personnel **must** be physically present at the stop. Yes _____ Initial _____ I understand that if no parent/legal guardian is present or a person identified to the school bus driver who is over the age of sixteen, your child may be turned over to the Syracuse Police Department Child Protective Unit, or returned to the assigned school or a designated school. Yes _____ Initial _____ I understand that curb-to-curb is required for any mental illness diagnosis (including ADHD). Yes ____ Initial _____ I understand that medication, a doctor's order, and action plan must be in the school nurse's office for all asthma/seizure/allergy requests. Yes _____ Initial _____ School Nurse Initial that order is in place _____ (Application will not be processed without this). This application must be completed every year and it may take up to **ten** days for transportation to begin. Parent/Guardian Signature _____ Date _____
For SCSD Medical Director's use Only	Start Date _____ Expiration Date _____ Winter Months Only ☐ (Nov. 1st through April 15th) **Type of Service Recommended:** **Unsupervised House Stop:** ☐ No parent or guardian needs to be present **Nearest Corner Stop:** ☐ Walking distances to pick-up points vary according to grade level. Grade levels K-8 will not be required to walk distances in excess of 2 blocks; grades 9-12 will not be required to walk distances in excess of 3 blocks **Curb-to-Curb:** ☐ A curb-to-curb identified stop requires a parent or guardian to meet the child at the bus door. If there is no parent/guardian at the bus door, the child may be turned over to the school. This service is not available on dead-end streets. **Wheelchair Bus:** ☐ **Comment:** _____
Disposition	☐ Approved ☐ Denied _____ _____ SCSD Medical Director or Designee Date Rev 8/2017

Please send completed application and a copy of your child's current physical examination to: Syracuse City School District, Health Services, 725 Harrison St., Syracuse, NY 13210 or fax to 315-435-4859. Incomplete applications will be returned and will delay the approval process.

Provider's Statement for **TEMPORARY** Transportation for Medical Reasons
(To be completed by medical provider)

Student's Name _____ School_____

Recent physical examination (**within one year**) must accompany this request.
Date physical exam was done: _____

……

For asthmatic conditions:

Child MUST have medications, provider's orders and asthma action plan in school for emergency purposes.

What medication(s) is your patient on?_____
What are triggering factors?_____
Stability of the medical condition (please check one) ☐Good ☐Fair ☐Poor. Please explain if fair or poor:_____
Are there any medical restrictions for gym class, recess or sports participation? ☐Yes ☐No

……

For psychiatric conditions (including ADHD):

What is the diagnosis?_____
What medication(s) is your patient on?_____
Is your patient undergoing therapy? ☐ Yes ☐ No If no,. why not? _____
Does your patient require supervision at the bus stop? ☐ Yes ☐ No If no, please explain why student needs transportation. _____

_____

……

For all other conditions:

Child MUST have, if applicable, medications, provider's orders, and an appropriate action plan (seizure or allergy) in school for emergency purposes.

Diagnosis/reason for transportation_____
Medication(s) prescribed for diagnosis_____

_____

_____ _____ _____

Provider's Signature **<u>Provider's Stamp Required</u>** Date

Please send completed application and a copy of your child's current physical examination to: Syracuse City School District, Health Services, 725 Harrison St., Syracuse, NY 13210 or fax to 315-435-4859. Incomplete applications will be returned and will delay the approval process.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO SCHOOLS

Please sign this so that we may get health information from your child's doctor.

Student Name: _____DOB: _____ Date: _____

As the parent/guardian of the child named, the completion of this form authorizes your doctor, _____ to disclose your child's confidential health-related information to his or her school.
(Name of Doctor)

The purpose for disclosing this information is to promote the accurate exchange of health information and for the coordination of care and treatment with the child's school. This is important information for many reasons. For example the school may need to know this information in order to give medications, monitor the child's illness, and keep track of immunizations.

This authorization limits the disclosure of information to the following:

- ☐ Immunization information
- ☐ Physical exam reports
- ☐ Laboratory tests
- ☐ Medications and treatments

This authorization form does not allow the disclosure of confidential health information that is given special protection under the law. This includes HIV-related information, substance abuse information, psychiatric information and genetic information; the disclosure of this information requires a different specific form.

The information will be disclosed to the school in the school district indicated below until you tell us that the child is no longer an enrolled student at the school. You may revoke this authorization at any time by notifying the child's healthcare provider in writing. Revoking this authorization means that we will no longer disclose the child's information to their school. The child's healthcare will not be affected if you do not authorize us to disclose their information to the school. In other words, we will not refuse your child treatment if you do not sign this authorization. The information we disclose to the school may be redisclosed to others by the school if the school is not required under law to protect the confidentiality of this information. You will be given a copy of this completed authorization to keep for your records.

Child's Name (print)	Date of Birth
Parent/Guardian's Name (print)	Relationship
Parent/Guardian's Signature	School

Please return to School Nurse