SYRACUSE CITY SCHOOL DISTRICT
Health Services
Anthony Q. Davis, Sr., Superintendent of Schools

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:
Medical transportation is for a short time only. Even if your doctor fills out the form, this does not mean that your child will automatically get transportation. If your child has a condition that requires medical transportation, they may also be restricted from other school activities such as physical education and sports. Should application(s) for medical transportation exceed a six month period, the District will refer the student for evaluation by the Section 504 Committee or the Committee on Special Education, whichever is appropriate.

Requests for medical transportation will be granted for students who are unable to ride a standard school bus or who are unable to walk the distance between their home and school. Examples of reasons for medical transportation may include the following, **if** they prevent a child from reasonably accessing school:

- A child who uses a wheelchair, crutches, or a walker
- A child who is unable to walk more than 50 feet due to a debilitating cardiopulmonary or neuromuscular condition.
- A child with **severe** asthma, a heart condition, or another medical condition that can cause significant fatigue when walking distances from home to school – These students will need a letter of justification from a pulmonologist, cardiologist or other specialist.
- A child with autism, mental illness, or an intellectual disability who cannot ride a traditional bus safely (temporary transportation provided only until evaluation by the CSE)
- A child on oxygen or a ventilator

A physical exam completed within the last 12 months MUST be submitted with the application or application will not be processed.

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 **by an adult**.

Curb-to-curb will be determined on a case-by-case basis. If your child has curb-to-curb medical transportation, this means that a parent or guardian **MUST MEET** the bus for pick-up in the morning and drop-off in the afternoon/evening.

If the application is approved, transportation may take up to 15 days to begin. If your child qualifies for medical transportation, a letter will be sent home with your child **FROM THE OFFICE OF THE SCHOOL THEY ATTEND**. If they do NOT qualify, you will receive a letter from Health Services.

Please give the completed application form and a copy of your child's current physical examination to your child's school nurse, or send/fax to the address on the bottom of this application. 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/sm

SYRACUSE CITY SCHOOL DISTRICT
Health Services

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Transportation for Medical Reasons

Student's Name _____ Address _____

School _____ Grade _____ Date Approved _____

Parent/Guardian _____ Phone: Home _____ Work _____

Parent or Guardian Use	**This section to be completed and signed by parent or legal guardian. Please read the following carefully and sign at the bottom that you understand the following:** • **I understand that the District may use the information submitted in support of this request to evaluate whether my child may safely participate in other activities, including sports and physical education.** • **I understand that a copy of student's physical exam must accompany this request for all medical conditions.** • **I understand that if my child will be participating in athletics this year, they may not be eligible for medical transportation.** • **I understand that an incomplete application will be returned and may delay your request for medical transportation.** • **I understand that if curb-to-curb is required, a parent/legal guardian must be physically present at the stop.** • **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.** • **I understand that prescribed medication and a doctor's order must be in the school nurse's office for all asthma/seizure/allergy requests.** **Once this application is received, it may take up to 15 days for transportation to begin if approved by Health Services.** **Does your child have an IEP or a 504 Plan?** ☐ **IEP** ☐ **504 Plan** ☐ **No** **Parent/Guardian Signature** _____ Date _____
For SCSD Medical Director's use Only	Start Date _____ Expiration Date _____ ☐ Winter Months Only (Nov. 1st until April 15) **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 an adult meet the child at the bus door. <u>This service is **not available** unless a bus may safely navigate the street of residence. Transportation must be consulted.</u> **Wheelchair Bus:** ☐ **Comment:** _____
Disposition	☐ Temporary ☐ Permanent ☐ Denied _____ _____ SCSD Medical Director or Designee Date Rev 5/2019

Please send completed application and a copy of your child's current physical examination to Your Child's <u>School Nurse</u> OR SCSD Health Services, 725 Harrison St., Syracuse, NY 13210 or fax to 315-435-4859. Incomplete applications will delay the approval process.

Transportation for Medical Reasons

PROVIDER'S STATEMENT for 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: _____

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For Asthmatic conditions:

☐ **Stable** ☐ **Unstable:** ____ **Moderate** ____ **Severe** ☐ **Winter Months Only**

PLEASE EXPLAIN: _____

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?_____

_____

Are there any medical restrictions for gym class, recess or sports participation? ☐ Yes ☐ No

Please note: medical transportation for students may also result in the student being restricted from physical education and sports. Please discuss this with the parent (guardian). For example a student with medical transportation may not be participating in sports such as, but not limited to, football, basketball, soccer, track, baseball, etc.

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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? _____

Name of Mental Health Provider_____

Does your patient require supervision at the bus stop? ☐ Yes ☐ No If no, please explain why student needs medical transportation_____

For Other Conditions:

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

Diagnosis/reason for transportation_____

Medication(s) prescribed for diagnosis_____

_____ _____ _____

Provider's Signature **Provider's Stamp Required** **Date**

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

Upon completion of this form we may need to contact the Provider to discuss this application.

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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 your child's School Nurse OR SCSD Health Services, 725 Harrison St., Syracuse, NY 13210 or fax to 315-435-4859. Incomplete applications will delay the approval process

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This Entire Section For School Nurse ONLY	**This Section to be completed by the school Nurse <u>ONLY</u>:** Name of Student _____ DOB_____ Does the child listed on this application currently participate in physical education or school sports? How frequently does the child listed on this application require attention for asthma exacerbations? Please be as specific as possible. Does the student have non-expired medication in place in school? _____ Does the student have a current medical provider's order in place for their medication in school?_____ Please state any other information you believe relevant to the child's medical history that will affect his/her receiving Medical transportation. Nurse's Signature _____ Print Name_____ School_____ Phone Ext:_____