



SEATTLE PUBLIC SCHOOLS APPLICATION FOR MEDICAL TRANSPORTATION

ID: _____ School: _____ Grade: _____

Name of Student: _____
(Last) (First) (Middle Initial) (Birthdate)

Parent/Guardian's Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Nature of Need: _____

(Parent/Guardian's Signature) (Date)

**APPLICATION MUST BE RENEWED EACH YEAR OR BEFORE TERMINATION DATE
IF THERE IS A CONTINUING NEED.**

To be Completed by Health Care Provider

Diagnosis: _____	

Recommendation: _____	

Number of blocks student can walk to bus: _____	Duration of transportation need: _____

(Signature of Health Care Provider)	Return Application To:
_____	Student Health Services
(Printed Name of Health Care Provider)	P.O. Box 34165, MS 31-650
_____	2445 Third Avenue South
(Address)	Seattle, Washington 98124-1165
_____	(206) 252-0751 - fax
(Phone)	_____
	(Date)

----- OFFICE USE ONLY -----

This student **G** is approved **G** is not approved for medical transportation to and from school because of a medical need.

Beginning date: _____ Ending date: _____

Reviewed by: _____ Date: _____