

Section I: STUDENT INFORMATION (completed by parent/guardian)

Name _____ Date of Birth _____

Address _____ Phone _____

Parent/Guardian _____ Bus. Phone _____

School _____ Grade _____ Sex: Male Female

Remarks: _____

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Section II: REPORT OF EXAMINATION AND RECOMMENDATION (completed by physician)

Diagnosis: _____
(Use A.M.A. Classification)

Date of Onset: _____ Is this child able to attend school? Yes No

CHECK SERVICES REQUIRED: Home Teaching Transportation to/from school

Special Needs (please explain): _____

_____ Estimated duration of service: _____

PHYSICIAN'S SIGNATURE _____ Date _____

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Section III: SERVICES TO BE PROVIDED

A. HOME TEACHING (for medically incapacitated) Starting Date _____

Hours per day _____ Days per week _____ Est. number of days _____

Principal's Approval _____ Date _____

B. TRANSPORTATION Starting Date: _____

From: _____ To: _____

by: District-owned Bus: Bus #: AM _____ PM _____
 Contractor: Company _____
Route # _____ Address _____

Estimated number of days _____ @ Daily Cost \$ _____ = Estimated Total Cost \$ _____

APPROVAL: _____ DATE: _____
Administrative Assistant for Business