STUDENT TRANSPORTATION OF PEEL REGION

S T O P R

REQUEST FOR TRANSPORTATION DUE TO MEDICAL REASONS
THIS FORM TO BE COMPLETED BY DOCTOR AND SCHOOL ADMINISTRATOR
AND
MUST BE RE-SUBMITTED EVERY SCHOOL YEAR

TFL006

Student's Name: _____ Phone # _____

Student's ID#: _____

Address: _____Unit # _____ City: _____

School: _____ Grade: _____

THIS SECTION TO BE COMPLETED BY PHYSICIAN

Nature of Illness: _____

Reason for Transportation: _____

Number of Weeks Transportation Required (min 4 weeks) _____

Are there any restrictions documented regarding physical activities? Yes _____ No _____

If yes, what are they? _____

Assistive Devices: Crutches ☐ Cast ☐ Ankle ☐ Half ☐ Full ☐

Wheelchair ☐ Assistive Walking Device ☐

Requests pertaining to Asthma must state that busing is a necessity and must identify that restrictions to participation in physical education and physical activities are required on an ongoing basis in order to receive consideration for transportation.

_____ _____ _____
Doctor's Signature Doctor's Phone Number Date

_____
Doctor's Name (Please Print)

THIS SECTION TO BE COMPLETED BY SCHOOL

Does the student participate in any of the following activities? **Gym,** Yes/No **Recess,** Yes/No
Extra-curricular sports, Yes/No **Field trips,** Yes/No **(Please circle all that apply)**

Is there medication in the school office? Yes ☐ No ☐

_____ _____ _____
Principal's Signature School Date

I acknowledge receipt of information pertaining to this student.

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