

# STUDENT TRANSPORTATION OF PEEL REGION

## STOPR

REQUEST FOR TRANSPORTATION DUE TO MEDICAL REASONS  
THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN  
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 <input type="checkbox"/>	Cast <input type="checkbox"/>	Ankle <input type="checkbox"/>
	Half <input type="checkbox"/>	Full <input type="checkbox"/>	
	Wheelchair <input type="checkbox"/>	Assistive Walking Device <input type="checkbox"/>	
<b>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.</b>			
_____	_____	_____	_____
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? <b>Gym, Yes/No</b> <b>Recess, Yes/No</b> <b>Extra-curricular sports, Yes/No</b> <b>Field trips, Yes/No</b> <b>(Please circle all that apply)</b>		
Is there medication in the school office?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
_____	_____	_____
Principal's Signature	School	Date
I acknowledge that the medical condition noted is valid.		