

**ROSEVILLE AREA SCHOOLS**  
**Transportation Adjustment Request: Medical Condition**

**TO BE COMPLETED BY PARENT OR GUARDIAN:**

Date form completed \_\_\_\_\_ School \_\_\_\_\_

Student Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Grade \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Signature \_\_\_\_\_

Home Phone: \_\_\_\_\_ Day Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ CSZ \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN**

1. Student diagnosis/impairment \_\_\_\_\_

\_\_\_\_\_

2. Please describe conditions which aggravate the student's condition \_\_\_\_\_

\_\_\_\_\_

3. Please indicate the distance the student can walk to school or to obtain bus service \_\_\_\_\_

\_\_\_\_\_

4. Expected duration of condition \_\_\_\_\_

\_\_\_\_\_

5. Please indicate any other medical restrictions \_\_\_\_\_

\_\_\_\_\_

Physician Signature: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

**FOR SCHOOL USE ONLY**

Bus service level provided: \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date \_\_\_\_\_

Approved by Student Services: \_\_\_\_\_ Date \_\_\_\_\_

Implemented by \_\_\_\_\_ Date \_\_\_\_\_

CC: School Nurse, Bus Company

RETURN TO: Roseville Area Schools District Center  
Transportation Department  
Fax 651-635-1640