OFFICE OF PUPIL TRANSPORTATION
44-36 Vernon Boulevard, Long Island City, NY 11101
Telephone: (718) 392-8855

Instructions for Completion of Medical Evaluation Requests 2018-2019

Please read carefully and follow all instructions – Incomplete or illegible requests or those missing required documentation cannot be processed and will be returned.

The Department of Education provides transportation to general education pupils who meet certain grade and distance requirements. Information on these requirements can be found at the following location: DOE grade-distance eligibility information.

These requirements specify that:

1. Transportation is provided only to grade and distance eligible pupils
2. With limited exceptions, only K through 6th grade pupils are entitled to yellow bus
3. Public transportation (MTA bus or subway) is equivalent to yellow bus as a form of transportation

Given this, requests for exceptions to the grade and distance requirements that apply to all general education pupils will only be approved when a clear and convincing reason is presented for the exception.

Parents or guardians may use the "Medical Evaluation Request" form to apply for an exception to OPT's normal rules in cases where the pupil's medical condition may require transportation. Please note that such exceptions are based on the ***pupil's*** condition. Exceptions are not made in cases where the parent or guardian has a medical condition or disability that may prevent them from accompanying their child to school.

The application for an exception to OPT's normal rules for general education transportation for medical reasons consists of two forms:

- The Medical Release Form ("HIPAA" form),
- The Medical Evaluation Request Form.

The one-page Medical Release Form is required by federal law and permits the pupil's school and health care providers to share private health-related information with the Office of Pupil Transportation. The three-page Medical Evaluation Request Form must be completed by the pupil's parent or guardian (page 1), the pupil's physician (page 2), and the pupil's school (page 3). Please pay particular attention to the information found on page four, below, regarding information that **must** be provided by your child's physician.

These instructions describe how each section of each form is to be completed and, if carefully followed, should permit a prompt and accurate assessment of the need for transportation. The instructions provided for parents and guardians are detailed both to attempt to minimize the need to request additional information, which will only delay the process, and also to facilitate translation of the information into multiple languages. The instructions for physicians and schools are more limited and will not be available in translation. The forms themselves must be completed using the English language.

When complete information is provided, a decision on a request can usually be made within fifteen (15) days. In exceptional cases or during particularly busy times of the year, a decision may take up to thirty (30) days. In some cases, when all of the information needed to make a final decision is not provided, a decision will be deferred and additional information will be requested. If a decision is

deferred and the additional information is not received within 60 days, the deferred request will be denied**. Illegible, incomplete or unsigned forms cannot be processed and will be returned to the pupil's parent or guardian.** Forms may be submitted by email or by US Mail at the address found on the form. Copies submitted by fax will not be accepted.

Instructions for parents or guardians for completion of the Medical Release ("HIPAA") Form

At each of the numbered locations on the form please **clearly** type or print the following **(all information is required)**:

1.1a Pupil's **last name** (surname or family name)
1.1b Pupil's **first name** (given name)
1.1c Pupil's **middle initial**, if any

1.2 Pupil's **date of birth** in MM-DD-YY format

1.3 Check ✓ to indicate the pupil's **gender** (1.3a for Male, 1.3b for Female)

1.4 Pupil's **student identification number** (OSIS number – contact the pupil's school if unknown)

1.5 Pupil's **grade** (grade number from K to 12 or NG for "non-graded')

1.6 Check ✓ to indicate the **pupil's classification** (1.6a for General Ed, 1.6b for Special Ed)

2 Print the **parent's or guardian's name** on the line provided

3 Indicate the **timeframe** for the medical records to be released by checking [✓] either 3.1and entering appropriate dates as MM-DD-YY or 3.2 to indicate all past, present and future periods. **This section MUST be completed.**

4 Indicate the **nature of the medical records** that may be released by checking [✓] either 4.1 to authorize release of **all medical records** or 4.2 to **exclude certain records** and then, if you wish to exclude certain records, also check [✓] box 4.21 to exclude mental health records, 4.22 to exclude records of communicable diseases, and/or 4.23 to exclude alcohol or drug abuse-related records. If other records are also to be excluded, check [✓] 4.24 and specify the records to be excluded on the line provided. **This section MUST be completed.**

6 Indicate the **expiration date** for the authorization by entering a date in MM-DD-YY format on the line provided. **This section MUST be completed.**

8 The parent or guardian must **sign and date** the form on the lines provided. **This section MUST be completed.**

Instructions for completion of Medical Evaluation Requests

Instructions for Completion of the Medical Evaluation Request Form

The Medical Evaluation Request Form contains three (3) pages.

- Page 1 (Sections 1, 2, and 3) should be completed by the pupil's parent or guardian,
- Page 2 (Section 4) should be completed by the pupil's physician,
- Page 3 (Section 5) should be completed by the pupil's school.

Instructions for parents or guardians for completion of the Medical Evaluation Form

At each of the numbered locations in **Section 1** on the form please **clearly** type or print the following **(all information is required)**:

1.11 Pupil's **last name** (surname or family name)
1.12 Pupil's **first name** (given name)
1.13 Pupil's **middle initial**, if any

1.2 Pupil's **date of birth** in MM-DD-YY format

1.3 Check ✓ to indicate the pupil's **gender** (1.31 for Male, 1.32 for Female)

1.4 Pupil's **student identification number** (OSIS number – contact the child's school if unknown)

1.5 Pupil's **grade** (grade number from K to 12 or NG for "non-graded')

1.6 Check ✓ to indicate the pupil's **classification** (1.61 for General Ed, 1.62 for Special Ed)

1.7 Indicate if **transportation is now provided by OPT** by checking [✓] 1.71 for "no" or 1.72 for "yes"

1.8 Indicate what **type of transportation is provided**, if any, by checking [✓] 1.81 for GE bus, 1.82 for SE bus, 1.83 for full-fare MetroCard, or 1.84 for half-fare MetroCard.

At each of the numbered locations in **Section 2** on the form please **clearly** type or print the following:

2.11 Parent or guardian's **last name** (surname or family name)
2.12 Parent or guardian's **first name** (given name)
2.13 Parent or guardian's **middle initial**, if any

2.2 Indicate parent or guardian's **title** by checking [✓] 2.21 for Mr., 2.22 for Mrs., 2.23 for Ms, or 2.23 for "other". Use the space following "other" [2.24] to indicate this title.

2.3 The parent or guardian's home address is presumed to be the pupil address. In this section enter:

2.31 The **street address** (house number and street name)

2.32 **Apartment number**, if any

2.4 **Borough** of home address (check [✓] M for Manhattan, BK for Brooklyn, Q for Queens, BX for Bronx, or SI for Staten Island

2.5 **City** of home address

Instructions for parents/guardians, con't.

2.7 **Zip code** of home address ["Zip + four" if known]

2.8 Enter the parent or guardian's **primary telephone number**

2.9 Enter an **extension** associated with the primary telephone number, if any

2.10 Enter the parent or guardian's **alternate telephone number**, if any

2.11 Enter an **extension** associated with the alternate telephone number, if any

2.12 Enter the parent or guardian's **e-mail address**, if any

2.13 The parent or guardian must **sign** the form in the space provided.

2.14 **Date** the form in the space provided.

In **Section 3** on the form please explain the **reason for the request.**

Clearly describe the pupil's medical condition or the circumstances that require transportation or the change in transportation that is being requested.

Instructions for physicians for completion of the Medical Evaluation Request Form

Please **clearly** type or print the information requested in **Section 4** (page 2) of the Medical Evaluation Request Form. **Illegible, incomplete or unsigned forms cannot be processed and will be returned to the pupil's parent or guardian.**

- Please identify the diagnosis or symptomatic indicators using appropriate ICD-9 or ICD-10 codes,
- Please include the results of any relevant diagnostic tests in the section related to the explanation of the diagnosis,
- If the pupil is receiving drug therapy, please include the names and dosages of all medications significant to the pupil's treatment in the section related to the present treatment,
- Please also include documentation and results for any specialty services or referrals in the section related to the present treatment,
- Please clearly print your name, **include your registry number**, and **sign and date the form** and return to the pupil's parent or guardian so that the remainder of the form for school-related information may be completed,
- Requests for medical exceptions are reviewed by physician employed by the NYC Department of Health and Mental Hygiene (DOHMH) working under the auspices of the DOE's Office of School Health (OSH). **OSH will not accept any request from OPT without a properly executed HIPAA form or in any case where the treating physician has not signed and dated the form and provided his or her medical license number.** These requests, if they are received, will be returned to the parent or guardian who, in turn, will need to return them to you for completion.

Instructions for schools for completion of the Medical Evaluation Request Form

Please carefully review the information provided by parents on page one of the request and assist them, if necessary, in identifying the student's grade, identification (OSIS) number, and GE or SE classification. Please **clearly** type or print ALL of the information required in Section 5 (page 3) of the form. **Illegible, incomplete or unsigned forms cannot be processed and will be returned to the pupil's parent or guardian.**

Please be particularly attentive to the following:

- Please provide the **name, primary telephone number *with* any required extension and e-mail address of the school's transportation coordinator** or pupil accounting secretary and the **name, primary telephone number *with* any required extension and e-mail address of the school's principal.**

- If the current school has little or no knowledge of the pupil's medical condition because the pupil has recently enrolled in the school, please assist the parent or guardian in getting records from the pupil's former school.

- If the current school does have knowledge of the pupil's medical condition, please provide clear information regarding any restrictions (limitations on physical education, for example), whether there is a "504" in place (if so, please attach a copy), and whether there have been any medical incidents involving the pupil while he or she has been at school.

- **Please also examine the information provided by the student's physician in Section 4,** page 2, to confirm that the physician has signed and dated the form and has provided his or her medical license number. If these are missing, the form should be returned to the parent/guardian so that the physician can provide this information. The DOE Office of School Health will not accept requests from OPT where this information is missing.

  The request form must be signed by the school principal or the principal's designee and, together with the Medical Release From ("HIPAA" form), may be emailed or mailed to the Office of Pupil Transportation at the address on the form. DOE Interoffice Mail or "regular" US mail is adequate. Certified, express or overnight delivery is not required. **DO NOT FAX** forms to OPT.

  Thank you for your cooperation.

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Medical Release Form 2018 - 2019

PLEASE PRINT CLEARLY IN DARK INK — ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

1.1 Pupil Name 1.1a Last name 1.1b First name 1.1c MI			1.2 Date of birth (MM-DD-YY) — —
1.3 Gender 1.3a☐ Male 1.3b ☐ Female	1.4 Identification Number	1.5 Grade	1.6 Classification 1.6a☐ General Ed 1.6b☐ Special Ed

2. I, ______________________________, the parent/guardian of the minor child named above, hereby authorize (a) any physician or health care professional, hospital, clinic or other medical facility, or any other health care agency or organization that has provided treatment, services, or benefits to my child, and (b) any teachers, guidance counselors, school nurses, and any other employees of any school that my child has attended and who have provided treatment, services or benefits to my child to disclose, give and release my child's individually identifiable health information and medical records to the NYC Department of Education, Office of Pupil Transportation, as specified below.

3. This authorization for release of information covers the period of health care:

   3.1 ☐ From ______________ to ______________ **OR** 3.2 ☐ all past, present and future periods. **MUST COMPLETE**
   Insert date MM-DD-YY Insert date MM-DD-YY

4. I hereby authorize the release of: **MUST COMPLETE _*EITHER*_ 4.1 _*OR*_ 4.2**

   4.1 ☐ The **complete health record**, including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse, **OR**

   4.2 ☐ I hereby authorize the release of the complete health record **with the exception of the following:**

   4.21 ☐ Mental health records
   4.22 ☐ Communicable diseases (including HIV and AIDS)
   4.23 ☐ Alcohol/drug abuse treatment
   4.24 ☐ Other (please specify): ______________________________

5. This information is to be used by the Office of Pupil Transportation to evaluate the need for school-related transportation for my child

6. This authorization shall be in effect until ______________ at which time this authorization expires. **MUST COMPLETE**
   Insert date MM-DD-YY

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

______________________________ ______________________________
Signature of Parent or Guardian **MUST BE SIGNED** Date **MUST BE DATED**

This form must be returned to the Office of Pupil Transportation with your Medical Evaluation request.

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Medical Evaluation Request 2018 - 2019

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1. PUPIL INFORMATION - ALL information is required

1.1 Pupil Name 1.11 Last name 1.12 First name 1.13 MI			1.2 Date of birth (MM-DD-YY) – –
1.3 Gender 1.31☐ Male 1.32 ☐ Female	1.4 Identification Number	1.5 Grade	1.6 Classification 1.61☐ General Ed 1.62☐ Special Ed
1.7 Is transportation now provided by OPT? 1.71 ☐ No 1.72 ☐ Yes	1.8 If yes, what transportation is provided? 1.81☐GE bus 1.82☐SE bus 1.83 ☐ MetroCard 1.84☐ Half-fare MetroCard		

2. PARENT / GUARDIAN INFORMATION

2.1 Name of parent or guardian 2.11 Last name 2.12 First name 2.13 MI		2.2 Title 2.21☐ Mr. 2.22 ☐ Mrs. 2.23 ☐Ms. 2.24 ☐ ________	
2.3 Home address 2.31 Street address 2.32 Apt. #		2.4 Borough ☐ M ☐ BK ☐ Q ☐ BX ☐ SI	
2.5 City	2.6 State NY	2.7 Zip Code +	
2.8 Primary telephone number – – – 2.8 Extension		2.10 Alternate telephone number – – – 2.11 Extension	
2.12 E-mail address of parent or guardian			
2.13 Signature of parent or guardian		2.14 Date	

3. REASON FOR REQUEST

Describe the medical condition or circumstances that require transportation or a change in transportation:

PLEASE SEE PAGES TWO AND THREE FOR ADDITIONAL REQUIRED INFORMATION

OFFICE OF PUPIL TRANSPORTATION

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PLEASE PRINT CLEARLY IN DARK INK—ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED

4. PUPIL'S MEDICAL INFORMATION

Pupil Name
Last name First name MI

Gender ☐M ☐F

Date of birth (MM-DD-YY) __ __ – __ __ – __ __

How long has this pupil been under your continuous care?

Indicate visit dates when you have seen the pupil in the last six months:

When did treatment begin for the condition that is the basis for this request?

Using ICD-9 OR ICD-10 codes, list the diagnosis or symptomatic indicators that require transportation

1.	3.
2.	4.

Provide a detailed explanation of the diagnosis:

Is this condition ☐chronic or ☐ acute?

If acute, what is the estimated duration?

Has there been any recent change in the pupil's condition? ☐ No ☐ Yes If yes, please describe:

Is the pupil: In a cast? ☐ No ☐ Yes Using crutches? ☐ No ☐ Yes Using a wheelchair? ☐ No ☐ Yes

Present treatment and recommendations:

Is your practice limited to a specialty? ☐ No ☐ Yes If yes, identify the speciality:

Physician's name [**please print**]
Last name First name MI

License number [**required**]

Address
Street number Street name

Telephone number __ __ __ – __ __ __ – __ __ __ __

City

State

Zip code __ __ __ __ __ + __ __ __ __

Physician's signature [**required**]

Date [**required**]

OFFICE OF PUPIL TRANSPORTATION

Medical Evaluation Request
Page 3

PLEASE PRINT CLEARLY IN DARK INK — ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED

5. SCHOOL-RELATED INFORMATION

Pupil Name

Last name First name MI

School name	ATS Code	OPT Code

Address	Borough
Street number Street name	☐ M ☐ BK ☐ Q ☐ BX ☐ SI

City	State	Zip Code
	NY	+

Transportation coordinator's name	E-mail address
Last name First name MI	
Primary telephone number – – – Extension	Alternate telephone number – – – Extension

Principal's name	E-mail address
Last name First name MI	
Primary telephone number – – – Extension	Alternate telephone number – – – Extension

Is the pupil's school activity restricted in any way? ☐ No ☐ Yes If yes, please explain:

Is there a school-based accommodation [504] in place for this pupil? ☐ No ☐ Yes If yes, please provide a copy of the 504 with this application.

Is the pupil's medical condition indicated on the pupil's school record? ☐ No ☐ Yes If yes, please describe:

Do school records indicate a history of medical episodes at school? ☐ No ☐ Yes If yes, please describe:

Is transportation now provided by OPT?	If yes, what transportation is provided?
☐ No ☐ Yes	☐GE bus ☐SE bus ☐Full-fare MetroCard ☐Half-fare MetroCard

If the pupil uses a school bus, what is the route number?	What is the medical alert code, if any?

What is the pupil's session time? AM to PM

What transportation is being requested? ☐GE bus ☐SE bus ☐Full-fare MetroCard

Signature of principal or designee	Title	Date

Email form to OPTMedicalTransportationRequests@schools.nyc.gov or mail to Office of Pupil Transportation, Medical Evaluation Unit, 44-36 Vernon Boulevard, Long Island City, NY, 11101; for assistance please contact OPT Customer Service at 718-392-8855.