SOUTH Colonie CENTRAL SCHOOLS

APPLICATION FOR APPROVAL OF TEMPORARY SPECIAL SERVICES

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

Name ______________________________ Date of Birth ______________

Address ______________________________ Phone ______________

Parent/Guardian ______________________________ Bus. Phone ______________

School ______________________ Grade ______ Sex: ❑ Male ❑ Female

Remarks: ____

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 ______________

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

1/94