

Appendix 1 b – Long Term Alternative Transport Assistance Form

Medical Report for Transport Assistance on Medical Grounds.

Pupil's Name..... D.O.B

Home Address.....

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School Attended.....

1: Please state the child's medical condition/s, clearly outlining the reasons why a request for alternative Transport Assistance on medical grounds is necessary.

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2: Please state if the child can travel on normal public transport i.e. Translink. If not please specify the reason(s) why.

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3: If alternative transport is recommended please advise when this should be reviewed:

3 months 6 months Annually

Other - please advise

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5: Other relevant information.

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Signed: _____

Date:

Designation: _____

Contact Address: _____

Contact Telephone Number: _____

Contact Email Address: _____