



COMMISSION SCOLAIRE SIR-WILFRID-LAURIER  
SIR WILFRID LAURIER SCHOOL BOARD

## SCHOOL TRANSPORTATION

# Student's Medical Certificate

### Step 1

#### To be completed by the school (before the medical specialist)

Name of the student: \_\_\_\_\_ Date: \_\_\_\_\_

Name of the school: \_\_\_\_\_ File #: \_\_\_\_\_

Transportation address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone number: \_\_\_\_\_ Homeroom: \_\_\_\_\_

The student participates in physical and sport activities: Yes  No

Signature of the School Principal: \_\_\_\_\_

#### To be completed by the parents or guardians

I hereby authorize the physician to provide the medical information required for the review of my child's file. I will assume any fees resulting from a medical examination. I am aware that the School Board will not reimburse any expenses incurred to obtain a medical certificate. ***I acknowledge that this request is valid for one year only and must be renewed on a yearly basis.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Step 2**

**TO BE COMPLETED BY THE MEDICAL SPECIALIST**

- Visual impairment: partial sight  blindness
- Permanent physical impairment, excluding chronic disabilities:   
Please specify: \_\_\_\_\_  
\_\_\_\_\_
- Permanent chronic physical impairment:
- Please specify: \_\_\_\_\_  
\_\_\_\_\_
- Epilepsy (not controlled by medication):
- Non-permanent chronic physical disability:  From \_\_\_\_\_ to \_\_\_\_\_
- Please specify: \_\_\_\_\_  
\_\_\_\_\_
- Asthma: mild  moderate  severe
- What factors can trigger an asthma attack: \_\_\_\_\_  
\_\_\_\_\_
- Other information: \_\_\_\_\_

I certify that \_\_\_\_\_ does suffer from the above mentioned impairment.

**Recommendations (considering his or her condition and the distance travelled):**

- The student can walk to school   
(maximum = preschool: 800 meters; elementary: 1600 meters; secondary: 1600 meters)
- The student can walk to a bus stop   
(maximum = preschool: 300 meters; elementary: 600 meters; secondary: 1000 meters)
- The student should be transported during the winter months, from \_\_\_\_\_ to \_\_\_\_\_
- The student should be transported during the entire school year
- Other recommendations: \_\_\_\_\_  
\_\_\_\_\_

Name of medical specialist (please print): \_\_\_\_\_

Signature of the medical specialist: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_ Licence # \_\_\_\_\_

**For the use of the Transportation Department**

Distance from the student's house to school: \_\_\_\_\_ meters. Transportation: accepted  denied

Verification with the School Board's physician: yes  no

Comments: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_