

## Instructions for Completion of Medical Variance Requests

The application for an exception to OPT's normal rules for General Education pupil transportation for medical reasons consists of two forms:

- The Medical Variance Release Form
- The Medical Variance Form

The one-page Medical Variance Release Form is required by federal law and must be completed by the pupil's parent or guardian to allow the pupil's health care providers to share private health-related information with the Office of Pupil Transportation. The three-page Medical Variance 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).

The instructions below describe how each section of each form is to be completed and, if carefully followed, should permit a prompt and accurate assessment of the medical 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 schools and physicians 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 medical variance request can usually be provided within fifteen (15) days. In exceptional cases or during particularly busy times of the year a decision may take up to thirty (30) days. Illegible, incomplete or unsigned forms cannot be processed and will be returned to the pupil's parent or guardian.

In order to maintain the legibility of these forms, we ask that you return the forms **BY MAIL**. Please **do not** send copies by fax.

### Instructions for parents or guardians for completion of the Medical Variance Release Form

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

- 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)
- 1.5 Pupil's **grade** (grade number from 1 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 Enter the **parent's or guardian's name** on the line provided

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- 3 Indicate the **timeframe** for the medical records to be released by checking [✓] either 3.1 and entering appropriate dates as MM-DD-YY or 3.2 to indicate all past, present and future periods
- 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.
- 6 Indicate the **expiration date** for the authorization by entering a date in MM-DD-YY format on the line provided.
- 8 The parent or guardian must **sign and date** the form on the lines provided.

### **Instructions for Completion of the Medical Variance Form**

The Medical Variance 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 Variance Form**

At each of the following numbered locations in **Section 1** on the form please **clearly** type or print the following:

- 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)
- 1.5 Pupil's **grade** (grade number from 1 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)
- 1.7a **Street number** of pupil's home address
- 1.7b **Street name** of pupil's home address
- 1.7c **Apartment number**, if any
- 1.8 **Borough** of pupil's home address (1.8a for Brooklyn, 1.8b for Bronx, 1.8c for Manhattan, 1.8d for Queens, 1.8e for Staten Island)
- 1.9 **City** of pupil's home address
- 1.10 **Zip code** of pupil's home address ["Zip + four" if known]

## Instructions for completion of medical variance requests

### Parent or guardian instructions, con't.

- 1.11 Indicate if **transportation is now provided by OPT** by checking [✓] 1.11a for “yes” or 1.11b for “no”.
- 1.12 Indicate what **type of transportation is provided**, if any, by checking [✓] 1.12a for GE bus, 1.12b for SE bus, 1.12c for full-fare MetroCard, or 1.12d for half-fare MetroCard.

In **Section 2** on the form please explain the **reason for requesting the medical variance**: clearly describe the pupil’s medical condition or the circumstances that require transportation or the change in transportation that is being requested.

At each of the following numbered locations in **Section 3** on the form please **clearly** type or print the following:

- 3.1a Parent or guardian’s **last name** (surname or family name)
- 3.1b Parent or guardian’s **first name** (given name)
- 3.1c Parent or guardian’s **middle initial**, if any
- 3.2 Indicate parent or guardian’s title by checking [✓] 2.2a for Mr., 2.2b for Mrs., 2.2c for Ms, or 2.2d for “other”. Use the space following “other” to indicate this title.
- 3.3 Enter the parent or guardian’s **primary telephone number**
- 3.4 Enter an **extension** associated with the primary telephone number, if any
- 3.5 Enter the parent or guardian’s **alternate telephone number**, if any
- 3.4 Enter an **extension** associated with the alternate telephone number, if any
- 3.7 Enter the parent or guardian’s **e-mail address**, if any
- 3.8 The parent or guardian must **sign** the form in the space provided.
- 3.9 **Date** the form in the space provided.

### **Instructions for physicians for completion of the Medical Variance Form**

Please **clearly** type or print the information requested in **Section 4** (page 2) of the Medical Variance Form. Illegible, incomplete or unsigned forms cannot be processed and will be returned to the pupil’s parent or guardian. If the pupil is receiving drug therapy, please include the names and dosages of all medications significant to the pupil’s treatment. Please also include documentation and results for any specialty services or referrals as well as results of any relevant diagnostic tests. Please 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.

**Instructions for schools for completion of the Medical Variance Form**

Please **clearly** type or print ALL of the information required in Section 5 (page 3) of the Medical Variance 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 only 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, and whether there have been any medical incidents involving the pupil while he or she has been at school.
- The variance request form must be signed by the school principal or the principal's designee and, together with the Medical Variance Release Form, should be returned to:

NYC Department of Education  
Office of Pupil Transportation  
Medical Variance Review  
44-36 Vernon Boulevard  
Long Island City, NY 11101-7006

In order to maintain the legibility of these forms, we **strongly recommend** that they be returned **BY MAIL**. Copies faxed to 718-482-3886 will be accepted, however, illegible copies due to poor fax transmissions will be returned.

Thank you for your cooperation.



**OFFICE OF PUPIL TRANSPORTATION**  
**ALEXANDRA ROBINSON** *Executive Director*  
 44-36 Vernon Boulevard  
 Long Island City, NY 11101  
 Telephone: 718-392-8855

# Medical Release Form

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			1.2 Date of birth (MM-DD-YY)		
1.1a Last name	1.1b First name	1.1c MI		—	
1.3 Gender	1.4 Identification Number	1.5 Grade	1.6 Classification		
1.3a <input type="checkbox"/> Male 1.3b <input type="checkbox"/> Female			1.6a <input type="checkbox"/> General Ed	1.6b <input type="checkbox"/> 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.  
Insert date MM-DD-YY      Insert date MM-DD-YY
4. I hereby authorize the release of:  
 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 assign school related transportation to my child if transportation is deemed appropriate.
6. This authorization shall be in force and effect until \_\_\_\_\_, at which time this authorization expires.  
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

\_\_\_\_\_  
 Date

**This form must be returned to the Office of Pupil Transportation with your medical variance request.**



**OFFICE OF PUPIL TRANSPORTATION**  
**ALEXANDRA ROBINSON** *Executive Director*  
 44-36 Vernon Boulevard  
 Long Island City, NY 11101  
 Telephone: 718-392-8855

**Medical  
 Variance**  
 2011—2012

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

**1. PUPIL INFORMATION**

1.1 Pupil Name			1.2 Date of birth (MM-DD-YY)		
1.1a Last name	1.1b First name	1.1c MI			
1.3 Gender	1.4 Identification Number		1.5 Grade	1.6 Classification	
1.3a <input type="checkbox"/> Male 1.3b <input type="checkbox"/> Female				1.6a <input type="checkbox"/> General Ed 1.6b <input type="checkbox"/> Special Ed	
1.7 Home address			1.8 Borough		
1.7a Street number	1.7b Street name	1.7c Apt. #	1.8a <input type="checkbox"/> BK	1.8b <input type="checkbox"/> BX	1.8c <input type="checkbox"/> M 1.8d <input type="checkbox"/> Q 1.8e <input type="checkbox"/> SI
1.9 City	State	1.10 Zip Code			
	NY				
1.11 Is transportation now provided by OPT?		1.12 If yes, what transportation is provided?			
1.11a <input type="checkbox"/> No 1.11b <input type="checkbox"/> Yes		1.12a <input type="checkbox"/> GE bus 1.12b <input type="checkbox"/> SE bus 1.12c <input type="checkbox"/> Full-fare MetroCard 1.12d <input type="checkbox"/> Half-fare MetroCard			

**2. PARENT / GUARDIAN INFORMATION**

2.1 Name of parent or guardian			2.2 Title		
2.1a Last name	2.1b First name	2.1c MI	2.2a <input type="checkbox"/> Mr.	2.2b <input type="checkbox"/> Mrs.	2.2c <input type="checkbox"/> Ms. 2.2d <input type="checkbox"/> Other
2.3 Primary telephone number		2.4 Extension	2.5 Alternate telephone number		2.6 Extension
2.7 E-mail address of parent or guardian					
2.8 Signature of parent or guardian				2.9 Date	

**3. REASON FOR VARIANCE 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**



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4. PUPIL'S MEDICAL INFORMATION

Pupil Name Last name First name MI		Gender <input type="checkbox"/> M <input type="checkbox"/> 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-CM codes, list the diagnoses or procedures that necessitate transportation				
1.		3.		
2.		4.		
Provide a detailed explanation of the primary diagnosis:				
Is this condition <input type="checkbox"/> chronic or <input type="checkbox"/> acute?			If acute, what is the estimated duration?	
Has there been any recent change in the pupil's condition? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe:				
Is the pupil: In a cast? <input type="checkbox"/> No <input type="checkbox"/> Yes      Using crutches? <input type="checkbox"/> No <input type="checkbox"/> Yes      Using a wheelchair? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Present treatment and recommendations:				
Is your practice limited to a specialty? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, identify the specialty:				
Physician's name Last name First name MI			Registry number	
Address Street number Street name			Telephone number       -       -	
City			State	Zip code         +
Physician's signature:			Date	



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5. SCHOOL-RELATED INFORMATION

Pupil name			
	Last name	First name	MI

School name	ATS Code	OPT Code

Address	Borough
Street number      Street name	<input type="checkbox"/> M <input type="checkbox"/> BK <input type="checkbox"/> Q <input type="checkbox"/> BX <input type="checkbox"/> SI

City	State	Zip Code
	NY	+      +      +      +      +

Transportation coordinator's name	E-mail address
Last name      First name      MI	

Primary telephone number	Alternate telephone number
Extension	Extension

Principal's name	E-mail address
Last name      First name      MI	

Primary telephone number	Alternate telephone number
Extension	Extension

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

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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 variance application.

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

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

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Is transportation now provided by OPT?	If yes, what transportation is provided?
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> GE bus <input type="checkbox"/> SE bus <input type="checkbox"/> Full-fare MetroCard <input type="checkbox"/> Half-fare MetroCard

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

What is the pupil's session time?    Regular day:      Extended day:

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

Signature of principal or designee	Title	Date

Please see "Instructions for Completion of Medical Variance Requests" for information on mailing to OPT

For assistance please contact OPT Customer Service at 718-392-8855