DEPARTMENT OF EDUCATION

P.O. Box 83720
BOISE, IDAHO 83720-0027

SHERRI YBARRA
STATE SUPERINTENDENT
PUBLIC INSTRUCTION

Student Transportation Section

CERTIFICATE OF MEDICAL EXAMINATION FOR INSULIN-TREATED DIABETES MELLITUS

Physician: The applicant identified below is subject to the provisions of § 33-1509 of Idaho Code and Administrative Rules of the Idaho State Board of Education (IDAPA 08.02.02.150-190). The applicant has applied for an exemption from Idaho physical requirements (ITDM) specific to driving a school bus in the State of Idaho. Granting of such an exemption is contingent upon the applicant submitting annual and quarterly medical statements to the State Department of Education. Your cooperation in this matter is appreciated.

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Name of Applicant: _____ DOB: _____

Address of Applicant: _____
(Street) (City) (State) (ZIP)

.....

REPORT OF EXAMINATION AND MEDICAL HISTORY BY OPHTHALMOLOGIST

TODAY'S DATE: _____

	Description of Query and Certification	YES	NO
1	I have thoroughly examined the applicant on the date indicated above and the applicant has no diabetic retinopathy. I am familiar with the current vision requirements in 49 CFR 391.41(b)(10) and the applicant meets the current vision standards in 49 CFR 391.41(b)(10), or the applicant has been issued a valid medical exemption particular to 49 CFR 391.41(b)(10).		
2	Applicant is negative for unstable advancing disease of the blood vessels in the retina or unstable proliferative diabetic retinopathy.		
3	Applicant has stable visual acuity (at least 20/40 Snellen in each eye separately, with or without corrective lenses).		
4	The applicant has provided me with a copy of the applicant's Application for Exemption and/or Application for Exemption Renewal and I concur with the applicant's declarations regarding the applicant's vision status as documented in the Application for Exemption and/or Application for Exemption Renewal and the date of the Application for Exemption and/or Application for Exemption Renewal reasonably corresponds to the date of this medical certification.		
6	It is my professional opinion that the applicant's diabetic condition and current vision status will not adversely affect the applicant's ability to safely operate a school bus in accordance with 49 CFR 391.41(b)(10).		
	Signature and Certification On Next Page		

Physician: Please provide additional comments related to your examination of the applicant, any recommended driving restrictions, recommended Insulin-Treated Diabetes Mellitus blood-sugar monitoring sequence, etc.

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_____

CERTIFICATION OF OPHTHALMOLOGIST

I, (*print full name*) _____, being licensed to practice medicine in the State of _____, certify that I have personally examined the individual named above on this date and that this is a true and complete report of medical examination and comprehensive vision evaluation according to the declarations herein made.

_____ _____
Signature of Ophthalmologist *Date*

_____ _____
Phone *Street Address* *City* *State* *Zip*

PLEASE RETURN THE ABOVE COMPLETED MEDICAL REPORT & CERTIFICATION TO:

Idaho State Department of Education
Director of Student Transportation
P.O. Box 83720
Boise, Idaho 83720-0027