

# Bus Driver's Blood Pressure Follow-up Form

NYS DMV Commissioner's Regulation Part 6.10

(Follow-up exam must be conducted by and signed by the driver's personal physician)

Bus Driver's Name: \_\_\_\_\_  
*(Name must correspond to name on driver's license)*

Bus Driver's Date of Birth: \_\_\_\_\_ Bus Driver's Social Security #: \_\_\_\_\_

"I \_\_\_\_\_  
*(Print Physician Name)* am acting as the bus driver's personal physician. He/She is under my care and treatment for high blood pressure. His/Her condition is stabilized by (indicate which):

Diet:

\_\_\_\_\_  
\_\_\_\_\_

Medication (define):

\_\_\_\_\_  
\_\_\_\_\_

Other means (explain):

\_\_\_\_\_  
\_\_\_\_\_

His/Her blood pressure reading today is: \_\_\_\_\_  
Systolic Diastolic

Date exam conducted by physician: \_\_\_\_\_

Physician signature (physician must sign): \_\_\_\_\_

Physician name (print or stamp): \_\_\_\_\_

Physician address:

\_\_\_\_\_  
\_\_\_\_\_

## IMPORTANT:

Completed follow-up form **MUST** be attached to physician's letterhead or voided prescription form



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