



School-To-School Transfer Form
20\_\_ - 20\_\_ School Year

Part I: STUDENT INFORMATION

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
Grade: \_\_\_\_\_ Current School: \_\_\_\_\_ [ ] Male [ ] Female
Parent/Guardian Name: \_\_\_\_\_
Home Address: \_\_\_\_\_
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Part I: TRANSFER INFORMATION

Transfer School: \_\_\_\_\_
Are there other siblings that attend this school? [ ] Yes [ ] No

Please list the following:

Table with 2 columns: Sibling's Name, Grade

Reason for Transfer: \_\_\_\_\_

Questions Related to Health Services at the Time of a Transfer Request:

- 1. Does your child have a health/medical condition? [ ] Yes [ ] No
If yes, Specify \_\_\_\_\_
2. Will your child need to receive injections at school? [ ] Yes [ ] No
If yes, Specify \_\_\_\_\_
3. Will your child need a nurse for a specific treatment/care? (such as g-tube feeding, catheterization)
[ ] Yes [ ] No
If Yes, Specify \_\_\_\_\_
4. Does your child have a life-threatening food allergy? [ ] Yes [ ] No
If yes, Specify \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Use Only
Student ID: \_\_\_\_\_ School \_\_\_\_\_ Date: \_\_\_\_\_
Approved Denied if denied, reason: \_\_\_\_\_

Date Parent/Guardian Contacted: \_\_\_\_\_ Date Letter Sent: \_\_\_\_\_