

Recommendation For Student Reassignment

Category: HARDSHIP

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Stude First N							Student's Last Nam						
Stude	nt ID				Grade			Date	of Birth	1			
Curre	nt Scho	ol											
Parent/Guardian's First Name							Parent/Guardian's Last Name						
Phone Number						Email Address							
Current Address (Where the Parent/Guardian and Student are residing)													
Street													
City						Sta	te				Zip Co	ode	
Provider's Name					Name of Pr			of Pra	actice				
Phone Number							Website						
I grant permission for the Howard County Public School System personnel to communicate with the provider named above. This release pertains only to records related to the reasons for the student's reassignment request and allows for the school system to release information and receive information from the named provider.													
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Diagnosis (Include DSM-V TR or ICD-10 Diagnosis and Code)								
Treatment plan								
Efforts made to in	clude sch	ool staff in th	ne treatment pla	an and the results of	the collabo	ration		
Efforts made to include school staff in the treatment plan and the results of the collaboration								
Reason why the student's medical and/or mental health diagnosis necessitates a change in school assignment								
Additional comments								
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Provider's Name				Name of Practice				
Phone Number				Email Address				
Address								
Professional Cred	lentials							
Provider's Signatu	ure				Date			
I understand that by typing my name, I am electronically signing this document.								