Recommendation For Student Reassignment

Category: HARDSHIP

Part I: To Be Completed By Parent/Guardian

Student's First Name		**Student's Last Name**	

Student ID		**Grade**		**Date of Birth**	

Current School	

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		**State**		**Zip Code**	

Provider's Name		**Name of Practice**	
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.

Parent/Guardian Signature		**Date**	

I understand that by typing my name, I am electronically signing this document.

Part II: To Be Completed By A Licensed Medical or Mental Health Professional

☐	**I am currently treating this student.**	☐	**I am no longer treating this student.**

How long has this student been under your care?		**Date of last visit**	

How often do/did you meet with this student?	Choose one

Diagnosis (Include DSM-V TR or ICD-10 Diagnosis and Code)

Treatment plan

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

Provider's Name		**Name of Practice**	
Phone Number		**Email Address**	
Address			

Professional Credentials	Choose one

Provider's Signature		**Date**	
I understand that by typing my name, I am electronically signing this document.			

PLEASE SUBMIT THE COMPLETED FORM TO RESIDENCY@HCPSS.ORG