Howard County Public School System

Supporting Document for Student Reassignment Request

OSRR use: Date form received:_____ Received by___ _____

Part I - To Be Completed by Parent/Guardian

Student's Last Name:_____ First:_____ Date of Birth:_____

Student ID:_____ Grade:____ Current School:_____

Parent/Guardian's Name: _____ Primary Phone:_____

Email Address:_____ Language spoken at home:_____ TTY needed ☐Yes ☐No

Current Address (where student is residing):_____

I grant permission for the appropriate school system personnel, including staff from the Office of Student Reassignment and Residency, the Office of Psychological Services, or the Office of Health Services, to communicate with_____ (provider's name). 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 Licensed Medical or Mental Health Professional

*In place of this form, you may write a letter that includes the following information. If needed, you can attach additional information with the completed form.

Choose one: ☐I am currently treating this student. ☐I am no longer treating this student.

How long has this student been your patient/client?_____

How often do/did you meet with the student? ☐ weekly ☐ biweekly ☐ monthly ☐ yearly ☐ other_____

Date of last visit:_____ Diagnosis (Include DSM-V TR or ICD-10 diagnosis and code):_____

_____

_____

Treatment Plan:_____

_____

_____

Efforts made to include the school in the treatment plan and the results of the collaboration:_____

_____

_____

Reason why the student's medical and/or mental health concern necessitates a reassignment to another school:_____

_____

_____

Additional comments:_____

_____

_____

Professional's Name:_____ Name of Practice/Agency/Business:_____

Office Address:_____

Phone:_____ Email:_____

Professional credentials:

☐ Licensed Physician ☐ Certified Nurse Practitioner ☐ Licensed Psychologist ☐ Licensed Psychiatrist ☐ Licensed Social Worker

Signature:_____ Date:_____

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

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