Fairfax County PUBLIC SCHOOLS
ENGAGE • INSPIRE • THRIVE

Student Transfer Request Form - Medical, Emotional, or Social Adjustment

Please complete this form in its entirely and submit to the registar at your current school of enrollment. The application cannot be processed until all required documentation is submitted and the application fee is paid to FCPS.

PART I: TO BE COMPLETED BY THE PARENT/GUARDIAN

Student Name			Student ID #	Requested School Year
Student Address	City	State	Zip Code	Phone
Parent or Guardian Name		Email		

The principal or designee may request a meeting prior to considering this request.

Have concerns been shared with school staff? ☐ Yes ☐ No

Forms and dates of communication _____

Staff Member(s) contacted _____

I hereby authorize _____ to release information from records or exchange information regarding
(healthcare provider)
my child, indicated above, to support my request for a student transfer for the purposes outlined below. I understand that this information may be written and/or verbal, and that all student transfer requests are discretionary and are subject to approval by FCPS.

_____ _____
Parent or Guardian Signature Date

PART II. TO BE COMPLETED BY AN INDEPENDENT (NON-FCPS) LICENSED HEALTH CARE PROVIDER, THESE INCLUDE PHYSICIANS, PSYCHOLOGISTS, SOCIAL WORKERS, OR COUNSELORS

The above-named student has requested a transfer of schools based on medical, emotional, or social adjustment. Please provide detailed documentation on how a school transfer supports the student's treatment plan by responding to each question below. ***This form is required documentation for transfer consideration and must be completed in its entirety annually***. All information provided with this request is subject to verification. Requested school must meet the requirements as identified in Regulation 2230 and cannot be determined by a health care provider recommendation.

Onset of Care	Date of Last Patient Visit

Current Diagnosis or Reason for Treatment.

☐ See attached

Treatment Plan including goals, frequency, duration of care, and medication.

☐ See attached

How is the student transfer medically critical/integral to the current treatment plan and goals for the student?

☐ See attached

Printed Name of Healthcare Provider Completing Form	Practice Name
Practice Address	

Phone Number	Fax Number	Email
Original Signature of Healthcare Provider (Required)		Date

Please provide any additional information or documentation on healthcare provider letterhead to attach with request.