

**STUDENT TRANSFER REQUEST ADDENDUM
STUDENT HEALTH INFORMATION**

Part I: TO BE COMPLETED BY THE PARENT/GUARDIAN	
Student Name:	School Year of Transfer Request:
Student Address:	
Assigned School:	Requested School:
Part II: TO BE COMPLETED BY A PHYSICIAN, LICENSED CLINICAL PSYCHOLOGIST, OR PSYCHIATRIST	
<p>The above-named student has requested a transfer of schools based on a physical or psychological reason. Please assist staff in making a determination by completing the questions below as applicable to this student, providing sufficient details to allow staff to make a decision. A medically-related transfer shall not be considered unless this form accompanies the transfer request.</p>	
Reason for Original Referral:	Date of Referral:
Current Diagnosis (please use diagnosis applicable to DSM or CPT codes):	
Treatment Plan and Prognosis:	
How would a transfer to the aforementioned requested school assist the student and you in working towards your treatment goals?	
Name of Medical Professional Completing this Form:	
Address:	
Telephone Number:	Fax Number:
Signature:	Date:
Has the parent signed a release for you to consult with Office of Student Services Staff? <input type="checkbox"/> Yes <input type="checkbox"/> No	

学生转学申请补充文件学生健康信息

第 I 部分：由家长/监护人填写	
学生姓名：	转学申请学年：
学生地址：	
分配到的学校：	申请学校：
第 II 部分：由医生、持证临床心理学家或精神科医生填写	
<p>上述学生因生理或心理原因申请转学。请协助工作人员根据该学生的具体情况填写以下问题，并提供足够的信息以便工作人员做出决定。除非转学申请附有此表格，否则与医疗相关的转学申请将不予考虑。</p>	
原转介原因：	转介日期：
当前诊断（请使用符合 DSM 或 CPT 代码的诊断）：	
治疗计划和预后：	
转学到上述申请的学校将如何帮助学生和您实现治疗目标？	
填写此表的医疗专业人员姓名：	
地址：	
电话号码：	传真号码：
签名：	日期：
家长是否已签署授权书，允许您咨询学生服务办公室工作人员？ <input type="checkbox"/> 是 <input type="checkbox"/> 否 	