HADDAM-KILLINGWORTH HIGH SCHOOL

95 Little City Road ~ Higganum, CT 06441
Tel: (860) 554-5750
Fax: (860) 345-4741
www.rsd17.org

Emily Baerlein, M.S.
Department Head

Alexandria Stone, M.S.
School Counselor

Rachel Pac
School Counselor

Darren Myers, M.S.
School Counselor

TRANSFER/WITHDRAWAL FORM

STUDENT NAME _____ YOG _____ HR# _____

WITHDRAWAL DATE _____ COUNSELOR _____ SASID# _____

This form must be signed by those listed below and parents/guardian.
All UFO's must be paid in full prior to withdrawal.

TEACHER	SUBJECT	GRADES TO DATE	BOOK(S) RETURNED YES/NO	INITIALS

NAME	DEPARTMENT	PLEASE CHECK FOR:		
	Homeroom Teacher	Locker cleaned out		
	Bookkeeper	UFO's checked/fees paid		
	Athletics	Uniforms/equipment returned		
	Library/Media Ctr.	Books, etc. returned		
	Cafeteria	Money owed		

Transferring to: (school name, town/city, state) _____

Forwarding Home Address: _____

Parent Signature: _____ Date: _____
Counselor Signature: _____ Date: _____

Revised 7-17-18

Regional School District No. 17

HADDAM-KILLINGWORTH HIGH SCHOOL
95 LITTLE CITY ROAD
HIGGANUM, CT 06441
P: 860-554-5750 / F: 860-345-4741

OFFICE OF PUPIL SERVICES
57 LITTLE CITY ROAD
HIGGANUM, CT 06441
P: 860-345-4244 / F: 860-345-3051

AUTHORIZATION FOR RELEASE OF INFORMATION TO/FROM REGIONAL SCHOOL DISTRICT 17 PUPIL SERVICES ~ COUNSELING DEPARTMENT

I hereby grant permission for the exchange of information regarding my child:

Student's Name:_____ Date of Birth:_____

between Regional School District #17 and:

Name of Person and/or Agency _____
Street Address _____
City, State, Zip _____
Fax Number _____

This authorization applies to the following information:

☐ Educational (Cumulative) ☐ Medical ☐ 504 ☐ SRBI/RTI ☐ Confidential File ☐ Disciplinary

DURATION:
This authorization shall become effective immediately and shall remain in effect until (enter date)_____ or for one year from the date of signature, if no date entered.

RESTRICTIONS:
Law prohibits the Requestor from making further disclosure of my health/education information unless the requester obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:
I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the persons on the front. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance to this Authorization.

RE-DISCLOSURE:
I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

_____ _____ _____
Printed Name Signature Date

Relationship to student: _____ Cell Phone: _____