



REQUEST FOR ELEMENTARY SCHOOL TRANSFER— SIBLING

Please provide all the information requested below for the application to be considered.

Date of Application: _____

Student Information

Last Name First Name Middle Name Date of Birth

Student and Primary Parent/Guardian Address: Street _____

City: _____ State: _____ Zip: _____

Parent/Guardian Information

Last Name First Name Mother Father Guardian

Home Phone # _____ Cell Phone # _____ Email Address _____

I certify that all of the information on this Request for Elementary School Transfer—Sibling is correct and true to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____

Transfer Request Information

Zoned School School Year & Grade Sibling's Name Sibling's School/Grade

Reason for request:

Comments (Please attach a separate sheet of paper, if needed): _____

For Department Use Only

Transfer Request Received On: _____ School Closest to Zoned Schools: _____

Transfer Decision: Approved Denied Date: _____

Transportation Provided: Yes No

Notes: _____

Please return this transfer request to the Department of Student Services and Equity, 1340 Braddock Place, 5th Floor Alexandria, VA 22314. The form can be emailed to students_services@acps.k12.va.us. If you have any questions, please call Ms. Linda Whitfield at 703-619-8333.