San Juan Unified School District
Admissions & Family Services
3700 Garfield Avenue, Carmichael, California 95608
P.O. Box 477, Carmichael, California 95609-0477
Telephone (916) 726-5826 FAX (916) 979-8187
Melissa Bassanelli, Superintendent of Schools
Debra Calvin, Ed.D., Assistant Superintendent, Educational Services
Brian T. Ginter, Director of Admissions and Family Services

OFFICIAL PARENT/ LEGAL GUARDIAN WITHDRAWAL REQUEST

All books, materials, athletic equipment, Chromebooks, etc. must be returned or paid for

I (parent)_____hereby request the withdrawal of my student(s):

STUDENT #1: _____DOB_____
ID#_____GRADE: _____
COUNSELOR: _____CASE MANAGER: _____
Current School: _____

STUDENT #2: _____DOB_____
ID#_____GRADE: _____
COUNSELOR: _____CASE MANAGER: _____
Current School: _____

STUDENT #3: _____DOB_____
ID#_____GRADE: _____
COUNSELOR: _____CASE MANAGER: _____
Current School: _____

New School: _____

Start Date: _____Withdrawal Date: _____

Student *Address (if different than what we already have on file)*:

_____

_____

Parent Signature: _____Date: _____
Parent Phone Number: _____
Parent Email:_____

For official office use

Received by: _____
Date: _____Time: _____Withdrawal Effective Date: _____
Program:_____

San Juan Unified School District
4825 Kenneth Avenue, Carmichael, CA 95608
P.O. Box 477
Carmichael, CA 95609-0477
Telephone: (916) 971-7525 Fax: (916) 971-7532

Authorization for Exchange of Confidential Information

Student Name: _____ Student ID#: _____ Date of Birth:_____

By signing this authorization, I am consenting to the exchange of information between:

Current School:	New School or Program:
Agency	*Agency*
Address	*Address*
City, State, Zip Code	*City, State, Zip Code*
Telephone Number Email Address	Telephone Number *Email*

Disclosure of information shall be limited to:

- ☐ Entire record (excludes HIV & Drug/Alcohol information)
- ☐ School information/Educational records
- ☐ Psychosocial information
- ☐ Treatment plan & progress
- ☐ Medical/Health information
- ☐ Psychological reports
- ☐ Psychiatric assessment
- ☐ Discharge summary
- ☐ Other: _____

Disclosing this information is for the following purposes:

- ☐ Educational assessment
- ☐ Educational planning
- ☐ Treatment planning
- ☐ other: (Be specific) _____

Expiration

This authorization shall remain valid until,.,--....,...,.----,----,,----,,- ------,,--,---,----,---
(must be no longer than a year from date of signature)

Your Rights

I understand that I have a right to receive a copy of this authorization. I have the right to refuse to sign this form. I understand that I may revoke or modify this consent at any time by providing written notice. Written revocation will be effective upon receipt but will not appy to information that has already been released in response to this authorization.

Restrictions

I understand that the health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and it is no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

Approval

A copy of this authorization is valid as an original.

Signature of Parent/Guardian _____ *Relationship to Student* _____ *Date* _____

Signature of Student _____ *Date* _____