



VIRGINIA BEACH CITY PUBLIC SCHOOLS

CHARTING THE COURSE

STUDENT PLACEMENT REQUEST SUPPLEMENT FORM (GRADES K-12)

MEDICAL-PHYSICAL/PSYCHOLOGICAL/SOCIAL ADJUSTMENT REASONS

Attach completed form and submit with Out-of-Zone Student Placement Request Form.

Section 1: Student Information

To be completed by parent/guardian

Student Name: _____ DOB: _____

Parent/Guardian Name: _____

Type of ☐ Medical-Physical Reasons

Request: *Section 2 must be completed by treating physician, nurse practitioner, or physician's assistant*

☐ Psychological/Social Adjustment Reasons

Section 2 must be completed by treating licensed clinical psychologist or mental health professional

Name of Licensed Professional: _____

Name of Practice/Office: _____

Section 2: Medical-Physical/Psychological/Social Adjustment Information

To be completed by the licensed professional

The parent/guardian has indicated that the above-referenced student is currently under your professional care and is seeking approval for the student to attend a school other than the one assigned.

To be considered for out-of-zone approval, Virginia Beach City Public Schools requires written verification of the student's medical-physical/psychological/social adjustment difficulties from the licensed professional providing treatment specific to the reason for the out-of-zone request. Written verification to support requests based on medical-physical reasons must be provided by the treating physician, nurse practitioner, or physician's assistant. Written verification to support requests based on psychological or social adjustment reasons must be provided by the treating licensed clinical psychologist or mental health professional.

The above referenced student has been under my medical care/treatment since _____ (date).

Diagnosis: _____

Impact of diagnosis on daily functioning: _____

Description of Current Treatment Plan:

(Include frequency, level of support, and/or medication) _____

Recommendation: ☐ Transfer **is** required as part of the student's treatment plan.

☐ Transfer **is not** required as part of the student's treatment plan.

Additional information

regarding recommendation: _____

Licensed Professional's Signature

Licensed Professional's Name (Print)

Date

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