Alexandria City Public Schools

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

_____	_____	☐Mother	☐Father	☐Guardian
Last Name	**First Name**			

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

Student's Grade for SY 20-21 _____ _____ _____

Sibling's Name **Sibling's School/Grade**

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

For Department Use Only

Transfer Request Received On: _____ **Transportation**: _____

Transfer Decision: ☐Approved ☐Denied **Date**: _____

Notes: _____

Please return this transfer request to the Department of Student Services, Alternative Programs and Equity, 1340 Braddock Place, 5th Floor, Alexandria, VA 22314. The forms can emailed to student_services@acps.k12.va.us. If you have any questions, please call Ms. Linda Whitfield at 703-619-8034.