HARFORD COUNTY PUBLIC SCHOOLS
BOUNDARY EXCEPTION APPLICATION

Student's Name _____ Birthdate _____

Student ID Number (*if known*)_____ Gender (M or F) _____ Grade applying for _____

Sibling with boundary exception *(yes)* _____ If yes, name _____ *(no)* _____

Applicant _____ Relationship to Student _____

Applicant must be an adult legally recognized as responsible for the student (i.e. parent, caretaker, foster parent).

Complete Address _____ *(include city and zip code)*

If the above address is different from the one that the school currently has in your child's record, an updated proof of residency must be submitted (e.g. BGE statement showing the above address) along with this application.

_____ _____ _____ _____

Home Phone *Work Phone* *Cell Phone* *Email*

Home School _____ Requested School _____

Requested School Year _____

Reason: (*please check primary reason)*

_____ A. Child Care (complete reverse side)
_____ B. Curriculum (program of study for high school)
_____ C. Hardship (documentation required)
_____ D. Child of HCPS Employee
_____ E. Moved during current school year
_____ F. Continuity for completing grades 5, 8, & 12

*Applications for kindergarten students will not be considered until after July 1 and require student to be enrolled in his/her home school prior to application being considered.

Please describe the reason why you are requesting to enroll your child in a school other than the home school. Please attach any pertinent information from other agencies or individuals that support your child's need for this boundary exception.

_____
_____
_____
_____

PLACE OF EMPLOYMENT

Name of Parent/Guardian 1 : _____
Place of work _____ Hours_____
Address _____ Telephone _____
HCPS employee ID number _____ (if applicable)

Name of Parent/Guardian 2: _____
Place of work _____ Hours_____
Address _____ Telephone _____
HCPS employee ID number _____ (if applicable)

Applicant, if not Mother/Father:
Place of work _____ Hours_____
Address _____ Telephone _____
HCPS employee ID number _____ (if applicable)

PLEASE COMPLETE REVERSE SIDE OF FORM

CHILD CARE PROVIDER VERIFICATION

(TO BE COMPLETED BY PROVIDER)

Name of Provider or Facility _____

Address _____ Telephone _____

_____ receives child care services on_____ at _____.
(Name of Child) (Days of the Week) (Times)

_____ _____
Signature of Provider Date Relationship to Child

NOTE: A Pupil Personnel Worker will call the Provider or Facility to verify the child care information as stated above is accurate.

---

*By signing this application, I attest the above information is true and accurate. *If it is determined that information has been falsified the boundary exception will be revoked immediately.*

_____
Applicant's Signature Date

If any of the conditions or circumstances on this application change, you MUST immediately notify the Pupil Services Office below:

ABERDEEN PUPIL SERVICES OFFICE
ATTN: EUNICE DAVAGE-JONES
111 MOUNT ROYAL AVENUE
ABERDEEN, MD 21001
410-273-5514

The deadline for applications is June 1

For Office Use Only

PPW ☐Approved ☐Denied ☐Deferred

Receiving School Principal ☐Approved ☐Denied ☐Deferred Date: _____

Rev 12/13/19