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.

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<tr>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
<th>Email</th>
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Home School __________________ Requested School __________________

Requested School Year __________________

Reason: (please check primary reason)

_____ A. Child Care (complete reverse side)   _____ D. Child of HCPS Employee

_____ B. Curriculum (program of study for high school)   _____ E. Moved during current school year

_____ C. Hardship (documentation required)   _____ 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 _______________________
______________________________________________________________________________
receive 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:

HAVRE DE GRACE PUPIL SERVICES OFFICE
ATTN: MARIAH BACHMAN
401 LEWIS LANE
HAVRE DE GRACE, MD  21078
410-939-6612

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