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.

<table>
<thead>
<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 _________________________

_________________________________________________________________________ receives child care services on________________________ at _________________.

(Days of the Week)                       (Times)

(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:

PATTERSON MILL PUPIL SERVICES OFFICE
ATTN: JOHANNA DELUIGI
85 PATTERSON MILL ROAD
BEL AIR, MD  21015
410-638-4215

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