Involuntary Transfer
Olympic High School

MT. DIABLO UNIFIED SCHOOL DISTRICT
OLYMPIC HIGH SCHOOL REFERRAL FORM
INVOLUNTARY TRANSFER

Administrator's Conference Date: _____

_____ _____
Student's Name Student Number

_____ _____ _____ _____
School now attends Grade Date of Birth Age

:_____ _____
Student's Address No. Street Apt No. City Zip Phone No.

_____ _____
Parent's/Legal Guardian Name(s): Phone No.

_____ _____ _____
Parent's/Legal Guardian Address (if different) Father's Work Phone Mother's Work Phone

REASON FOR REFERRAL: Please check one or more (if applicable).

☐ **A.** The student committed an act enumerated in Education Code 48900 _____

_____

☐ **B.** Student truant. SARB Hearing Date:_____ ☐ SARB Notified

☐ **C.** Student has not earned 60 credits by the age of 16. Total Credits _____

☐ Comments_____

_____

NOTE: All credits earned in the alternative programs will be accepted upon transfer to home school. (Ed. Code 51225.3)

If student has been enrolled in other program(s), check the appropriate program(s), **if none, check here**: ☐

☐ Resource Program ☐ GATE ☐ Home & Hospital ☐ Foster Child/Homeless
☐ Special Day Class ☐ CIS ☐ Olympic/NSHS ☐ County Day
☐ 504 Accommodations ☐ TLC ☐ Adult Education ☐ Diablo Community Day
☐ EL/CELDT Level_____ Date_____

CAHSEE: ☐ Not taken ☐ English/Language Arts Score_____ ☐ Math Score_____

- Probation: ☐ Yes ☐ No Name of Probation Officer: _____
- Satisfactory progress is expected. Failure to do so will result in consideration of other educational alternatives.

I have included the following:
☐ Cumulative Folder ☐ Current Attendance ☐ Transcript ☐ IEP ☐ 504 Plan
☐ Current Schedule ☐ Discipline Record ☐ SARB Form ☐ PBT Summary Report Date:_____

Within five (5) calendar days of receipt of this administrator's request for transfer and all supporting documentation, the Director, Student Services shall notify the parent/guardian that a request for transfer has been made and inform them of their right to request a meeting with the Alternative Education Transfer Panel regarding this referral. The parent or guardian must request this meeting within five (5) calendar days of the notice of right to request a meeting.

_____
Signature of Administrator School of Residence

_____
Print Name of Administrator

☐ Hearing Requested Date Requested: _____

Hearing Date: _____

☐ Approved ☐ Denied

_____
Signature of Director, Student Services

☐ Appeal to Assistant Superintendent Date: _____ ☐ Approved ☐ Denied

_____ _____
Assistant Superintendent Pupil Services and Special Education Date