SOMERVILLE PUBLIC SCHOOLS
DEPARTMENT OF SPECIAL EDUCATION

TRANSFER/TERMINATION OF SPECIAL EDUCATION SERVICES

Student's Name:_____ Date:_____

School:_____ Grade/Class:_____

TRANSFER

Student will transfer from _____ to _____
(school name) (new school name)
on _____. New liaison will be _____
(Date) (name)
Date new liaison contacted: _____. Date IEP forwarded to new liaison:_____.

TERMINATION

Please check one

☐ Moved to another city
All services terminated **date**:_____
Forwarding Address (if known):_____

_____

☐ Parent request (***REQUIRED*** attach letter from parent or have parent signature on this form.) **date**:_____

_____
Parent Signature

☐ Achievement of goals
List services terminated and **date**:_____
_____
Parent Signature Required:_____

☐ Quit School **date**: _____

_____ _____
Signature of Liaison Signature of Service Provider

Somerville Public Schools
Special Education Department
8 Bonair Street
Somerville, Massachusetts 02145

Telephone: (617) 625-6600 x 6800
Fax: (617)591-7901

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

This is to authorize the Somerville Special Education Department to OBTAIN FROM / RELEASE TO: circle one / both

Date:

Name of Agency, Hospital, Doctor, Institution, Company	
Address	
City, State, ZIP Code	

The following information only:	☐ Medical Records ☐ Psychological Assessment ☐ IEP ☐ All Assessments ☐ Other: _____
For the purpose of:	☐ Educational Planning ☐ Other: _____ _____
This information pertinent to:	Name: _____ DOB: _____ Address: _____ City, State: _____
Please forward the requested information to:	Department of Special Education Evaluation Center 8 Bonair Street Somerville, MA 02145 ATTENTION:

None of these special education records will be released to any person or agency without prior written consent of parent, guardian, or educational advocate specifying which of these records are to be released and to whom. All relevant records with respect to the identification, evaluation, and placement of your child will be maintained in a central location and available for your examination on an appointment basis. Also, this authorization may be withdrawn by the parent, guardian, or advocate at any time in the future. This permission form is valid up to 1 year from the date of signature, unless otherwise specified below.

_____

_____

Approved Signature: Date:	Relationship (Parent, Guardian, Educational Advocate):

If moving, please provide forwarding address: