



# Manhasset Public Schools

## Counseling Department

### Schedule Change Request

Name of Student \_\_\_\_\_ Counselor \_\_\_\_\_

Grade \_\_\_\_\_ Homeroom Teacher (1<sup>st</sup> period) \_\_\_\_\_ Date \_\_\_\_\_

Schedule changes are discouraged and must be approved by the appropriate administrator. Absolutely no change will be made based on teacher preference, or without an acceptable explanation. Once you have obtained the signatures from the individuals indicated below, please return the completed form to the Counseling Office.

Please indicate the change you are requesting:

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Reason for this request:

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Parent Signature \_\_\_\_\_ Phone# \_\_\_\_\_

Email address \_\_\_\_\_

All signatures must be obtained before any changes can be made.

District Coordinator's Signature \_\_\_\_\_ Date \_\_\_\_\_

Approved \_\_\_\_\_

Disapproved \_\_\_\_\_

Teacher's Signature \_\_\_\_\_ Date \_\_\_\_\_

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Counselor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Student must follow the original schedule, until a new schedule is issued.