District Logo

Date Received: _____ / _____ / _____
Time Received: _____ / _____ / _____
FOR OFFICE USE ONLY

Transitional Kindergarten Acceleration Parent Request

Child's Name: _____ _____ _____
(Please Print) *First* *Middle* *Last*

Birth Date: _____ Sex: M F
Month Day Year

Home Address: _____
Street City State Zip Code

Home Telephone: _____

Father's Name: _____ Mother's Name: _____

Work/Cell Number: _____ Work/Cell Number: _____

Siblings: (Names/Ages)

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Has your child attended preschool? Y N If yes, how many years? _____

Name of Preschool(s) Attended:

_____

List reasons why you think your child should be considered for acceleration and moved from the transitional kindergarten program to the traditional kindergarten program.

_____
_____
_____
_____
_____
_____

I acknowledge that I have received Transitional and Traditional Kindergarten program information from the district.

_____ _____
Parent/Guardian Signature Date

Please submit this form with your Acceleration request to the district office. You will be notified by district staff following a review by the school board.

District Name
Address
Phone Number
Website