Gaston County Schools
Medical Transfer Request – Details Form

Name of Student: _____ Grade (2025-26): _____

Requested School: _____

1) Description of illness, handicap or disability of student: _____

_____

_____

2) Statement setting forth in detail how the reassignment will benefit the student:_____

_____

_____

_____

_____

3) Beginning date of treatment for the illness, handicap or disability of student:

_____

4) Termination date (if applicable) of treatment for illness, handicap or disability of student:

_____

5) Prognosis: _____

_____

_____

_____

Medical Official's Signature: _____ Date: _____

Medical Official's Printed Name: _____

Signature of ___ Physician
___ Psychologist
___ Psychiatrist

**********FOR GCS USE ONLY**********

Gaston County Schools Medical Review Officer Review Conducted On: _____

Conclusion of the Review: _____ Approved _____ Denied

Notes: _____

_____

Medical Review Officer's Signature: _____