Bishop Luers High School

Home of the Knights

REQUEST FOR CLASS CHANGE

NAME_____**GRADE**_____ **DATE**_____

Class to be dropped_____

Class to be added_____

Class to be dropped_____

Class to be added_____

This request was initiated by:

_____Student _____Teacher _____Parent _____Counselor _____ Other

Reason for requested change:

Notice to parents: A request has been made that your son/daughter change a class. Please review the information, mark whether or not you give consent for the class change, and sign the form. No charge will be made until the student obtains the necessary signatures of teachers and parents. Nor will changes be made until the business office has signed off on the $15.00 course change fee. Classes may be changed only within the first two weeks of the semester.

_____I agree with the requested class change

_____I do not agree with the requested class change

_____ _____

signature of parent/guardian date

Course change fee was paid to the business office on _____

date

Receipt number _____ Receipt issued by_____

initials

(GUIDANCE OFFICE USE ONLY)

Student_____ Date of Request_____

Course dropped_____ Course added_____

Course dropped_____ Course added_____

Class change was completed on_____

Class change was not completed because: _____

Counselor signature_____