APPLICATION FOR RESCHEDULING
A SAC

NAME: ___________________________ HOMEROOM: ___________________________

SUBJECT: ___________________________ TEACHER: ___________________________

Please state below reason/s for this application:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Student Signature: ___________________________ Date: ___________________________

This application must be accompanied by a statement completed by the student’s doctor, treating specialist or other relevant professional.

This documentation must be presented to the Senior Studies Co-Ordinator.

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APPLICATION: □ Granted □ Rejected

Senior Studies Co-Ordinator: ___________________________ Date: ___________________________

Subject Teacher Signature: ___________________________ Date: ___________________________

Rescheduled Date for SAC: ___________________________

Parent Signature: ___________________________
I hereby authorise Dr./Ms./Mr./Mrs. ________________________ to release my personal/medical information to Star of the Sea College.

Student's Signature: ____________________________________________

Student's Name: ______________________________________________

Student's Address: _____________________________________________

Date of Birth: _________________________________________________

Date of Diagnosis: _____________________________________________

Diagnosis (if appropriate): ______________________________________

Please describe the impact of the illness/condition/situation on the student.

_________________________________________________________________

Please specify level of impact: none, mild, moderate, severe.

_________________________________________________________________

Other comments:

_________________________________________________________________

_________________________________________________________________

Name of doctor/treating specialist/other professional: ________________________

Profession: __________________________ Telephone No.: __________________________

Fax No.: __________________________

Place of Work: __________________________ Ref. / Provider No. __________________________