



Student Withdrawal Form

Date received: _____

Date of last class: _____

****Must be submitted at least 30 days prior to last class.**

Parent's Name _____

Phone Number(s) _____

Student(s) Name (s) _____

Class Day(s) (circle): Mon Tues Wed Thurs Fri _____ Time(s): _____

(If more than one student, circle days and write students' name above day. Include ALL class times.)

Level: _____

Reason for withdrawal: Moving Medical Schedule conflict

Other (explain): _____

Comments: _____

Parent Signature _____

Date _____

Office use:

Cancelled class(s): _____ Remove from autopay: Done

Refund due? Yes No If Yes, amount: \$ _____ Submit refund request: Done