RECORDS REQUEST FORM

Student's Name: Last, First, Middle: ____

______/______/__________ Student's Date of Birth (mm/dd/yyyy) ______ Student's Current Grade

RECORDS TO BE RELEASED BY:

Name of School: ____

Street Address of School: ____

City, State, Zip Code: ____

Area Code and Telephone Number of School: ______________________________

Area Code and Fax Number of School: ______________________________

AUTHORIZATION FOR RELEASE OF STUDENT' RECORDS

You are authorized to release school records of the above names student to St. Peter the Apostle School. Please send a complete and official copy of the records indicated below:

Permanent Record	Standardized Test Scores
Social Security Card	Immunization Form
Birth Certificate	Discipline Record
IEP (Individual Education Plan)	Psychological Evaluation

Signature of Parent/Guardian: ______________________________ Date: ________________

FOR OFFICIAL USE:
Records Requested By: ______________________________ Date Requested: __________

"It is not necessary to have written consent of parents to release records to officials of other schools or school systems in which the student seeks or intends to enroll." Privacy Rights of Parents and Students Act. Page 1213, **subpart D 99 30 (b).**