



Our Lady of the Angels

REQUEST FOR RELEASE OF STUDENT RECORDS

Name of Student _____ Entering Grade _____

I give my permission for the release of educational records of this student
from

(name & address of school where child is currently enrolled)

Signature of Parent _____ Date _____

Records requested are Academic, Health/Dental, Guidance, Discipline, Psychological, special education, student assistance, and other available records pertaining to this student.

These records are being requested because this student has transferred to:
Our Lady of the Angels School
404 Cherry Street
Columbia, PA 17512

I understand this release is specifically for the records listed above and only to the recipient noted. I further understand I have the right to inspect and receive a copy of the said records via a conference.

Signature of Principal _____ Date _____

OFFICE USE ONLY

Health Records _____(date)

Academic _____(date)