Request for Student Records (new students)

Date of Request _____

Student Information

Student Last Name _____

Student First Name, Middle Initial _____

Place of Birth (City/State) _____ Grade _____ Date of Birth ___/___/___

Parent/Legal Guardian Information

Last Name _____ First Name _____

Relationship to Student _____ Phone # _____

Current Address _____

City _____ State _____ Zip Code _____

I hereby request that records for the student identified above be provided to the school identified below. I certify that as parent/legal guardian and/or student, I have the legal right to authorize the release of this information.

Parent/Legal Guardian Signature _____

The records requested include the following:

- Cumulative record of grades, attendance, and standardized test scores
- Special needs evaluation, diagnostic report, and current prescriptions for adjustments
- Immunization record, vision and hearing screening, and special health care need information.

Records Requested from

School Name _____ Phone # _____

School Address _____

City _____ State _____ Zip Code _____

Send Records to:

School Name **St. Patrick Catholic School** Phone # **636-332-9913**

Email **principal@stpatsch.org, office@stpatsch.org** Fax # **636-887-2065**

School Address **701 S. Church Street**

City **Wentzville** State **MO** Zip Code **63385**