

STUDENT RECORD RELEASE

SIGNATURE REQUIRED

Date: _____

TO RELEASING SCHOOL COUNSELOR:

SCHOOL NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Dear Counselor:

My children have been withdrawn from your school. Please release their academic and health records to the following church-school. Thank you.

ACCEPTING CHURCH-SCHOOL

Name of Church-School

Address

City, State, Zip

Students' Names (Last name first)	Age	Grade level at time of withdrawal

Signature of Requesting Parent

Signature of Principal