

**Request for Student Records/Transcript
Parental Consent for Release of Student Information**

Please print clearly.

School _____

Street Address _____

City _____ State ____ Zip _____

Mailing Address (if different from above): Phone # _____

P. O. Box # _____ Fax # _____

City _____ State ____ Zip _____

By my signature, I hereby grant permission for the release of the cumulative folder, medical records, immunization records, achievement test scores, most recent and past grade reports, and/or transcripts of _____, whom I certify to be my child or legal
(full legal name of student)
ward. This student attended your school during the _____ - _____ school year and was in Grade _____.

The records listed above are to be released and sent to the following school:

**Bay Knoll Seventh-day Adventist School
2639 East Ridge Road
Rochester, NY 14622-3021
Phone / Fax (585) 467-2722**

Requested by: _____

Parent / Guardian Signature _____ Date _____

Address _____ Phone # _____

City _____ State ____ Zip _____

For Office Use Only:

Date Sent _____

Date Files Rec'd. _____