

Saint Joan of Arc School



Request for Release of Student Records

Date: _____

We hereby request all records to be sent to St. Joan of Arc School regarding the following student(s):

(student's name)

(DOB)

(student's name)

(DOB)

_____ Official School Transcript

_____ Standardized Test Scores

_____ Medical/Immunization Records

_____ Psychological Records

I hereby grant permission for you to release all records for the above student(s) for the following purpose: **Student Transfer**

Records to be sent to: **Saint Joan of Arc School
498 East Washington Street
Chagrin Falls, OH 44022**

Parent /Guardian Signature

Secretary Signature