RELEASE OF ACADEMIC/MEDICAL RECORDS

My child will not be returning to St. Elizabeth Ann Seton Academy and I hereby authorize the release of their school records and/or medical records to their new school.

Child's Name: _____
Last First Middle

Address: _____

City/Town: _____ State: _____ Zip: _____

Telephone: _____ Current Grade: _____

Please release these documents to:

Name of school attending: _____

Address: _____ City:_____

State: _____ Zip: _____ Telephone: _____

_____ _____
Parent/Guardian Signature Date