



SCHODACK

CENTRAL SCHOOL DISTRICT

AUTHORIZATION FOR THE RELEASE OF STUDENT RECORDS

_____ (grade _____) has begun the registration process in the Schodack CSD
(Student name)

PLEASE SEND US ANY OF THE FOLLOWING INFORMATION THAT MAY BE AVAILABLE:

1. Academic Records
2. Attendance Records
3. Health and Immunization Records
4. Individual Education Program (IEP) or 504 Plan (Confidential)
5. Psychological test results
6. Standardized/State Test Results
7. Science Labs

PLEASE FORWARD INFORMATION TO THE CIRCLED LOCATION BELOW:

CES	Maple Hill Jr./Sr. HS	PPS
Attn: Regina Maier	Attn: Mary Southard	Attn: Jill Hanrahan
(518)732-7755 rmaier@schodack.k12.ny.us	(518)732-7701 (518)732-0494(fax) msouthard@schodack.k12.ny.us	(518)732-2523 (518)732-2184(fax) jhanrahan@schodack.k12.ny.us

Thank you.

I hereby grant permission for _____ fax # _____ to
release all medical and school records for my child _____ DOB _____.

(Signature of Parent/Guardian)

*For Office
Use Only*

Request for Records Sent to Former School _____
Date Initials