Request for Student Records

To: (School Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please release all information below for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Student Name)

* Certified Copy of Birth Certificate
* Transcript of Grades
* Release of Standardized Testing
* IEP or 504 Plan, meeting minutes, and evaluations
* Health and Immunization Records
* Psychological and/or Educational Evaluations
* Medical/Speech/Hearing Evaluations
* Disciplinary Records
* Permission to speak to school officials by phone
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All records should be mailed to: **Halifax Christian School**

 **3098 Halifax Road**

 **South Boston, VA 24592**

I hereby authorize my child’s school to release transcripts, test scores, and health information (including immunization records) and any confidential files to Halifax Christian School.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A ministry of South Boston Church of God

Halifax Christian School

3098 Halifax Road, South Boston, VA 24592 434.575.1325