

**ST. JOSEPH CATHOLIC HIGH SCHOOL**

TO:

_____		_____
Name of Student		School Last Attended
_____	_____	_____
Date of Birth	Grade	
		_____
		School Address and fax #

We request that you send the following official records of the above named student.

- \_\_\_\_\_ Cumulative Transcript
- \_\_\_\_\_ Psychological Evaluations
- \_\_\_\_\_ Health and Immunizations
- \_\_\_\_\_ Test Records
- \_\_\_\_\_ Withdrawal Grades
- \_\_\_\_\_ Days Absent to Withdrawal Date

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Parental Authorization for Release of Student Records

I hereby authorize the above school to forward all information including grades at the time of withdrawal, psychological evaluations and health records from my child's record as requested.

\_\_\_\_\_

Date Parent or Guardian Signature

Please send record to: (or fax 870-540-0345)  
St. Joseph Catholic High School  
1501 West 73<sup>rd</sup> Avenue  
Pine Bluff, AR 71603