St. Michael the Archangel Regional School
51 W. North St.
Clayton, N. J. 08312
856-881-0067

REQUEST FOR PUPIL RECORDS

______________________________ ____________
School Transferred From Date

____
Street Address

____
City State Zip

The above named school is authorized to release the school records of the student listed below who has recently enrolled in our school.

__________ __________ __________
Name Grade(in Sept.) Date of Birth

Records to be Released:

Cumulative School Record	X
Health/Medical Records	X
Immunizations	X
Attendance Information	X
Psychological Records (If applicable)	X
Transfer Card	X
Child Study Team Report	X
Other (Specify)	

RECORDS TO BE SENT TO:

St. Michael the Archangel Regional School Or Fax 856-881-4064
51 W. North St.
Clayton, NJ 08312

I have enrolled ______________________ in St. Michael the Archangel Regional School, Clayton, NJ and give permission to the authorized personnel to secure all records listed above regarding this student.

______________________________ ____________
Signature of Parent/Guardian Date