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