DELAWARE CITY SCHOOLS

Copies:
Records Officer
Custodian of Records
Parent

CONSENT FOR RELEASE OF STUDENT RECORDS/STUDENT PERSONALLY IDENTIFIABLE INFORMATION

STUDENT: _____

ADDRESS: _____

AGE: _____ BIRTHDATE: _____ DATE: _____

A. You are authorized to release the records listed below, orally and/or in writing, for the above-named student to: (if self, give own name and address)

_____
Name

_____
Address

_____
City State Zip

B. Specific information to be released, orally and/or in writing: (Please check)

_____ All educational records and personally-identifiable information.
_____ All personally identifiable data on file.
_____ The following records only: (specify)

_____
_____
_____.

C. Reason for request: (Please check)

_____ To aid in present and future educational decisions.
_____ Other (specify): _____.

_____ _____
Date (Signature of parent/guardian/student*)
(*Student must be eighteen (18) years old or older)
Address: _____

****

FOR OFFICE USE ONLY

Date Data Released _____ by _____
(Name/Position)

Date Copies Mailed _____ by _____
(Name/Position)

6/05