



THE ST. AUSTIN SCHOOL

Request for Student Records

Student Information:

Name: _____ Applying for: _____
(Last) (First) (M.I.) (Grade)

Name: _____ Applying for: _____
(Last) (First) (M.I.) (Grade)

Name: _____ Applying for: _____
(Last) (First) (M.I.) (Grade)

Name: _____ Applying for: _____
(Last) (First) (M.I.) (Grade)

Name: _____ Applying for: _____
(Last) (First) (M.I.) (Grade)

The records requested include the following:

- Cumulative record of grades and attendance
- Standardized test scores
- Special needs evaluations, diagnostic reports and current prescriptive accommodations
- Health and immunization records

Parent / Guardian Authorization:

I / We hereby request that cumulative academic and health records for the student(s) identified above be provided to the school identified below. I certify that as a parent / legal guardian of this student, I have the legal right to authorize the release of this information.

Signature of Parent / Guardian: _____ Date: _____

Name of Parent / Guardian: _____
(Last) (First) (M.I.)

Signature of Parent / Guardian: _____ Date: _____

Name of Parent / Guardian: _____
(Last) (First) (M.I.)

Please send records to:

The St. Austin School
P.O. Box 6906
Chesterfield, MO 63006

For office use only:

Date received: _____ Received by: _____