Request for Academic & Medical Records

Records to be released from:

School Name ____

Street Address ____

City, State, Zip Code ______________________________________

Phone Number ____

Dear Admissions Director,

Our school has received an application for the following student(s):

Name ______________________________________ Grade______

Name ______________________________________ Grade______

Name ______________________________________ Grade______

Name ______________________________________ Grade______

As requested by the children(s) parents, please send a copy of all academic and health records for these student(s) to:

Grace Classical Academy
2416 Creswell Road
Bel Air, MD 21015
Attention: Admissions

____________________________________ ____________________________

Parent Signature *Date*