PELHAM HIGH SCHOOL
RECORD RELEASE AUTHORIZATION

The School District is required to obtain written consent from the parent or eligible student before a student's educational records are released to any party other than those who are permitted by law.*

STUDENT NAME:_____ MAIDEN NAME :_____
PARENT NAME (if under 18):_____
ADDRESS: _____ YEAR OF GRADUATION: _____
_____ DATE:_____
_____ PHONE:_____

RECORDS TO BE RELEASED: _____Transcript
_____ Letters of Recommendation
_____ Standardized Test Scores
_____ Health Records
_____ Special Education Records

RECORDS TO BE DISCLOSED BY:

Pelham High School
College and Career Counseling Department
85 Marsh Road
Pelham, NH 03076

RECORDS TO BE DISCLOSED TO:

_____
_____
_____
_____

By signing this form, I CONSENT to the release of information as described above.

AUTHORIZED SIGNATURE:_____

PRINTED NAME:_____

DATE:_____

*A student who is 18 years of age or older, or who is attending an institution of post secondary education.

This form can be mailed to the above address, e-mailed to phscounseling@pelhamsd.org, or faxed to (603) 635-3994.

Office Use Only:
Request Received: _____ *Records Sent:* _____