SPENCERPORT CENTRAL SCHOOL DISTRICT

Official Request for Records

***Check Boxes That Apply*:** **Date Needed By**_____

- ☐ **Official Transcript** - Number of copies needed_____
  (*Official Transcripts will be in a sealed envelope & Must remain in the envelope in order to be considered official*)
- ☐ **Unofficial Transcript** - Number of copies needed_____
- ☐ **SAT / ACT Scores**
- ☐ **Health/Immunization Record**
- ☐ **Special Ed Records** ○ **IEP** ○ **504** ○ **Psych Eval.** ○ **Other**_____
- ☐ **Graduation Verification** *(needed for job applications or other official needs).* **Letter Needed?** *(circle one)* Yes / No

- REQUESTOR'S NAME:_____
  (Maiden name or other name if applicable)
- DATE OF BIRTH:_____
- YEAR GRADUATED:_____
  (if not graduated, year of anticipated graduation)
- YOUR PHONE NUMBER(S):_____
- YOUR EMAIL ADDRESS:_____

College / Organization Name & Address where records should be forwarded (or email if applicable):

_____

_____

_____

OR → FAX NUMBER TO ATTN OF:_____

Please complete & Email, Mail or Fax this form to:

Email: asylvester@spencerportschools.org
Fax: 585-349-5280

Mail: Spencerport High School
Registrar's Office
2707 Spencerport Road
Spencerport, NY 14559

*Turnaround time is 5 business days *If need to contact: 585-349-5248

Our Mission is to educate and inspire each student to love learning, pursue excellence and use knowledge, skills and attitudes to contribute respectfully and confidently to an ever-changing global community.

RELEASE OF EDUCATIONAL RECORDS (7240.9)

I, _____ born_____

(Name) *(Date of Birth)*

give Spencerport Central Schools permission to release my educational and special needs records, all college entrance exams, resume and letters of recommendations will also be included to any School, College, Employer, or Military as requested.

VALIDITY PERIOD OF THIS FORM IS 5 YEARS

Signature: _____

Date: _____