



SPENCERPORT CENTRAL SCHOOL DISTRICT

RECORDS REQUEST FORM FOR FORMER STUDENTS

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 Pscyh Eval. Other _____

- **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 **→ FAX NUMBER TO ATTN OF:** _____

**Please complete & Mail this form along with the release to: Spencerport High School
 Registrar's Office
 2707 Spencerport Road
 Spencerport, NY 14559
 ~or~ FAX this to: 585-349-5280**

***Turnaround time is 5 business days
 *If need to contact: 585-349-5248 ~or~ csnyder@spencerportschools.org**

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: _____