PERMISSION TO RELEASE INFORMATION

Blue Springs South High School 1200 SE Adams Dairy Parkway Blue Springs, MO 64014

816-224-1315 Fax: 816-224-1783

	ve permission for the officials of the I understand a copy of this information		
Student's Name Street Address		Date of Birth Year of Graduation or year you would have graduated	
Felephone Number		Maiden Name or name you attended school	
TYPE OF RECORD	REQUEST (circle one)	OFFICIAL	UNOFFICIAL
Please send r	ecords to:		
Name of Scho	ol or Agency		
Address of Sc	hool or Agency		
City & State		Zip Code	Fax Number
hereby authorize disc	losure of the records listed below (che	ck).	
Cumulative Permanent School Records (Transcript/Test Scores)Health Records/Immunizations		Special Education RecordPsychological Reports & Evaluation Psychological TestsAll of the above, if applicableOther:	
Will pick up records (on:		
Signature of Student-If Age 18			Today's Date
Signature of Parent/Gu	ardian required if student is under 18		
			\$4.00 fee paid
			Date mailed or taken