Authorization of Release of Educational Records

Curt Cameron
Principal
Vermillion High School
1001 E. Main Street, Vermillion SD 57069
Phone: 605-677-7035
Fax: 605-677-7042

Guidance Office
Vermillion High School
1001 E. Main Street
Vermillion SD 57069

NAME OF STUDENT ______________________ DATE OF BIRTH __________

ADDRESS OF STUDENT ______________________________________

I hereby authorize:

NAME ______________________________ POSITION ______________

INSTITUTION ____

ADDRESS ____

to release the following records:

________ Academic

________ Health

________ Disciplinary

________ Testing

________ OTHER ____

________ Special Education

________ Attendance

________ Counseling

________ ENTIRE RECORD

I specifically request that the above information be released to:

NAME ____

ADDRESS ____

for the purpose of ________________ CONTINUED EDUCATION

________________ HEALTH CARE

________________ OTHER ____________________

____

This authorization shall be in effect for one year from this date, unless revoked by me in writing at any time, except to the extent that action has already been taken to comply with it.

____
Student's name (age 18)

____
Parent/Guardian

Date ____________________

Witness ____________________