

STUDENT RECORD REQUEST RELEASE



INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:
Name: Legacy Traditional Schools	Name: Legacy Kids Care (LKC) – <i>Please list campus name</i>
School:	Title: Admin and Staff
Street Address:	Street Address:
City/State/Zip:	City/State/Zip:
Phone Number: Fax:	Phone Number:

Parent/Guardian would like the following records and/or information released to Legacy Kids Care (LKC):

- | | |
|---|---|
| <input type="checkbox"/> Health & Immunization Records | <input type="checkbox"/> Section 504 Plan Records |
| <input type="checkbox"/> Psychological Evaluation Records | <input type="checkbox"/> Verbal Communication |
| <input type="checkbox"/> Special Education Records | <input type="checkbox"/> Written Communication |

Other: _____

Student Name	Date of Birth	Grade

I hereby authorize the school named above to release information, both verbally and in writing, to Legacy Kids Care (LKC).

Signature of Parent/Guardian

Date

Signature of LKC Administrator

Date