SKAGWAY SCHOOL DISTRICT
REQUEST FOR TRANSFER OF RECORDS

TO: Releasing School or Agency_____

Address_____

City_____State_____Zip_____

RE: Student(s) Name	Birth Date	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Receiving School:

Skagway School District
P.O. Box 497
Skagway, AK 99840

Phone No. 907-983-2960
Fax No. 907-983-2964

Please include records of grades, test scores, health records, attendance records, psychological testing, special education records, Chapter/LAP records, and any other cumulative record information your district may have that will help us aid the educational process of the child.

I authorize the release of records to the Skagway School District. The reason for this authorization is _____.

I acknowledge notification of this transfer of records as required by the Family Education Rights and Privacy Act of 1974 and understand that I have the right to receive a copy at my own expense, if requested, and have an opportunity for a hearing to challenge the content of records. I understand that the information transferred will be treated in a confidential manner and will not be transmitted to a third party without my consent.

_____ _____
Parent/Guardian Signature Date

PLEASE RETURN COPY OF THIS FORM WITH RECORDS.