AUTHORIZATION TO RELEASE INFORMATION

TO: _____

_____

_____

Please forward all academics, psychological, IEP's and health records, or any other pertinent information or records you deem appropriate for the purpose of assisting us in providing the best possible educational program for:

_____ _____ _____
Student's Last Name First Middle

_____ _____
Date of Birth Present Grade or Placement

Please send these records to:

SANDOVAL ELEMENTARY SCHOOL
300 E. PERRY AVE
SANDOVAL, IL 62882
(618) 247-3450 Fax: (618) 247-3161
Email: mschlau@sandoval501.org

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I hereby authorize the release of school records of _____ to be sent to Sandoval Community Unit District 501 (Sandoval Elementary School). The agency receiving these records agrees not to transfer information to any other person or agency without the proper consent as outlined in the Illinois School Student Record Act of 1975. This release is effective for 30 days from the date of signing.

_____ _____
Signature of Parent or Legal Guardian Date

PLEASE RETURN THIS COPY WITH THE STUDENT RECORDS. THANK YOU!

_____ _____
Melissa Schlau, School Secretary Date