



Release of Records Authorization Form

Student's Name: _____

Students Date of Birth: _____

Student's Last Grade Completed: _____

I hereby give permission for the release of all school and health records, including any Special Education information regarding the student listed above to St. Gilbert Catholic School.

Name of Previous School: _____

Email address: _____

Street Address: _____

City, State, Zip Code: _____

Date: Signature of Parent Legal Guardian: