RELEASE FORM

AUTHORIZATION OF RELEASE OF EDUCATIONAL RECORDS

Please complete the authorization below: (Please print or type)

Student's Last Name	First	M.I.	Birth Date	Grade

Current or Most Recent School Attended	Address	City	State	Zip

In accordance with federal regulations regarding the privacy rights of parents and students under *The Family Educational and Privacy Act of 1974,* the undersigned hereby consent to the release to Providence Classical School all educational records about the above named individual who is applying to Providence Classical School, including recommendations and such other information as may be requested.

Date	Signature of Parent/Legal Guardian

TO THE PRINCIPAL OR REGISTRAR/GUIDANCE COUNSELOR:

The student named above plans to attend Providence Classical School. We would appreciate a prompt return of the following items, if applicable:

A transcript of the student's record, including grades.
A copy of the student's complete test profile.
A copy of all psychological reports.
A copy of Individual Education Plan.
A copy of Immunization records
A copy of Special Education Placement forms.

This information should be mailed, emailed, or faxed to:

Providence Classical School
6000 Easter Circle
Williamsburg, Virginia 23188
(757) 565-2900
(757) 565-3720 FAX
pcs@pcsvirginia.org