



STUDENT RECORDS RELEASE AUTHORIZATION

Please complete the information below and return this form to the school requesting records.

PREVIOUS SCHOOL INFORMATION

Name of previous school: _____ Telephone number: _____
Address: _____ Fax number: _____

STUDENT INFORMATION

Student's Name: _____ Applying for Grade: _____ Date of Birth: _____
Student's Name: _____ Applying for Grade: _____ Date of Birth: _____
Student's Name: _____ Applying for Grade: _____ Date of Birth: _____

I hereby authorize the release of the records listed below for the above student(s).

RECORDS REQUESTED

- ☐ Latest Grade Report ☐ Test Scores (FCAT, SAT, ACT, etc.) ☐ Medical Records
☐ Cumulative Records ☐ Exceptional Educational Records ☐ IEP/504
☐ Special/Psychological Educational Testing

Signature of parent or guardian: _____ Date: _____

PLEASE SEND RECORDS TO

Registrar, Port Charlotte Adventist School
2100 Loveland Blvd., Port Charlotte, FL 33980

Sincerely, _____

PCAS Official