

Request for Transfer of Student Records

Student

Last Name	First	Middle Initial	Grade
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Please use one form per student.

School Requested From

Name of School _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____ Fax _____

I request that any education, testing, and health records or other pertinent information that you may have regarding this student be sent to Capital Christian School at the address above.

Signature _____

Date _____