



THE MARSHALL SCHOOL

Authorization to Request / Release Student Records

To: _____ (School Name)
 _____ (Address)
 _____ (City, State ZIP)
 _____ (Phone Number)

I request that all records listed below for

_____ *Last* _____ *First* _____ *MI*
 _____ *Date of Birth* _____ *Grade*

be sent to:

The Marshall School
5707 Salem Run Blvd.
Fredericksburg, VA 22407
TEL: (540) 412-5107
FAX: (540) 412-5308

Records include:

_____ Academic Records - attendance - transcripts	_____ Test Records - standardized test results
_____ Health Records - immunization record	_____ Confidential Records - All Special Education Records
_____ Other	

Parent or Guardian's Signature

Date

Parent or Guardian's Printed Name