# STUDENT RECORD RELEASE

SCHOOL OF TOMORROW™

## To Releasing School Counselor:

______________
Date

______________________________________________
School Name

______________________________________________
Address

______________________________________________
City | State/Province | ZIP/Postal Code

Dear Counselor:

My child(ren) has (have) been withdrawn from your school. Please release their academic and health records to the following school. Thank you.

**Accepting School**

______________________________________________
School Name

______________________________________________
Address

______________________________________________
City | State/Province | ZIP/Postal Code

| Students' Name(s) (Last name first) | Age | Grade level at time of withdrawal |
|---|---|---|
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______________________________ ______________________________
Signature of Requesting Parent/Guardian | Signature of Receiving Principal

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