Plattsburgh City School District

AUTHORIZATION TO RELEASE OFFICIAL STUDENT TRANSCRIPT or IMMUNIZATION RECORDS

All fields must be completed and signed form must be received before transcript will be released. Incomplete forms will not be honored.

Please print all information clearly and accurately.

Personal Information:

Name: _____ SSN: (last four #'s)_____

If attended under a different name, print name here: _____

Phone number: _____ DOB: ____/____/____

Date last attended:_____ Graduated from PHS: Yes _____ No _____

This request is for _____ Official Transcript _____ Immunization record

Please print the address or Fax number to which you would like a copy of your records sent.

_____ _____

_____ _____

_____ _____

Please read and sign below:
By signing this form, I authorize the Plattsburgh City School District to release my official transcript or immunization record. I also certify that the record I am requesting to be released is my own. I further understand that if I sign for another individual's record to be released, I agree to be held liable.

STUDENT SIGNATURE: _____ DATE: _____

If your date of birth is 1993 or after
Fax the completed form to: 518-561-5907
Or: email to lschudde@plattscsd.org
Or: Mail the completed form to:

Plattsburgh High School
1 Clifford Drive
Plattsburgh, NY 12901

If your date of birth is 1992 or earlier
Fax the completed form to: 518-561-6605
or email to cleclair@plattscsd.org
or Mail the completed form to:

Plattsburgh City School District
49 Broad Street
Plattsburgh, NY 12901