

RECORD RELEASE FORM

TO: _____

EMAIL: _____
FAX # _____

FROM PARENT:

I hereby grant / have granted permission for release of any and all information from the records you hold concerning the student(s) listed below:

Student's Name(s) _____

Please mail all the checked school records to the address below:

- 1. Progress/Academic Records _____
- 2. Behavioral/Disciplinary _____
- 3. Health/Immunization/Physical _____
- 4. Birth Certificate _____
- 5. Other: _____ _____

Wade Christian Academy
4300 North Wickham Road, Melbourne, FL 32935
321.259.6788 FAX: 321.425.4174

I certify that I am the parent or legal guardian of the above named student(s).

(Parent/Guardian Signature)

(Date)

Thank You.

(Administrative Assistant, Wade Christian Academy)

(Date)