

LAVACA PUBLIC SCHOOLS

TRANSCRIPT REQUEST

FAX: 479-674-0087

PHONE: 479-674-5612

DATE: _____

I, _____,

am requesting a copy of my (check all that applies):

transcript immunization special education records

Mailed to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Please sign in signature area, do not type

Signature: _____

Email copy: _____

The following information is needed to complete your request:

Name at

graduation: _____ Date of

birth: _____ Year

graduated (479-674-0087) or Email completed form to Dawn.Smithson@lavacaschools.com

For Office Use only:

Faxed

Mailed

Pick-up

Signature: _____

Date: _____