RECORD RELEASE FORM

TO: ____

____

____

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)