ST. CASIMIR'S SCHOOL

330 2nd Ave. SW
Wells, MN 56097
507/553-5822
casimir@bevcomm.net

CONSENT TO RELEASE PRIVATE DATA

Student's Name _____ DOB _____ Grade _____

Parent/Guardian _____ Phone # _____

Address _____

Name of Previous School: _____

Street Address: _____

City, State, Zip: _____

Please send the following records to St. Casimir's School at the address listed above:

- Official Educational Records
- Health Records—including immunization and medically related services
- Special Education/IEP Records
- Attendance
- Psychological Reports
- Standard Testing Scores
- Teacher, Counselor, Staff Observations
- Social Work Reports
- Chemical Abuse/Dependency Reports

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the release of school records to St. Casimir's School for the student/s listed above. I realize this authorization takes effect the day that I sign it.

_____ _____

Parent/Guardian Signature Date

In accordance with State and Federal legislation, parental permission must be obtained before records can be released by previous school (Minnesota Public Law, Chapter 479 and Federal Statute, Public Law 93-380).