



THE DELPHIAN SCHOOL™

Student Records Release

To: _____
NAME OF FORMER SCHOOL

STREET ADDRESS CITY STATE ZIP

I hereby authorize the transfer and release of ____progress records ____behavioral records____all educational and medical records concerning:

NAME OF STUDENT DATE OF BIRTH GRADE

To the Admissions Office of The Delphian School:
This release does not waive any rights to challenge the contents of these records by the parents, guardian, or emancipated minor as prescribed by law.

I understand that these are confidential records and will not be shown to any other third party without parent's/student's permission.

SIGNATURE OF PARENT/GUARDIAN (OR STUDENT IF ADULT)

DATE

This information will be used in preparing the student's program at The Delphian School. If student withdrew prior to the end of semester/quarter, please indicate quality of progress to date of withdrawal:

Please forward materials to: The Delphian School
Admissions Office
Attn: Records Section

The Delphian School • 20950 SW Rock Creek Road • Sheridan, Oregon 97378
PHONE: 503-843-3521 • FAX: 503-843-4158 • EMAIL info@delphian.org

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