

Permission for Release of Student Records

By signing this form, you give permission for Galatia School District

to release the educational records of:

Name of student(s) _____

Date of birth _____

Last grade attended _____

School or Individual to Which Educational Records May Be Released

Name: _____

Address: _____

Phone # _____ Fax # (if faxing records) _____

Parent/Guardian

Signature: _____ date: _____