



Records Release

The following student will be attending Chelsea Public School.

Name _____ D.O.B. _____ Grade _____

**Please send their complete records including academic, health, and special services to:
Registrar, Chelsea Public School, 6 School St, Chelsea, VT 05038**

As parent/legal guardian, I agree that records and information regarding above student may be released from

(Name of School)

(School Address)

(school phone number)

(school fax number)

The files at Chelsea Public School are open only to authorized personnel including the student, the administration, and the parents or legal guardian. No information will be released from our files without proper authority.

Parent/Legal Guardian's signature

Parent's name printed

Phone number

Student's signature (if age 18)

Date

Chelsea School Use:

Date Records Requested by Fax _____ by Mail _____

Date Records Received _____