

# TRIAD MATH AND SCIENCE ACADEMY

## STUDENT RECORDS REQUEST

FOR OFFICE USE ONLY

Verified: \_\_\_\_\_

Date Released: \_\_\_\_\_

Signature: \_\_\_\_\_

Date of Request: \_\_\_\_\_ Phone Number: \_\_\_\_\_

1. Please print the name as it appears on the student records:

\_\_\_\_\_ Date of Birth: \_\_\_\_\_  
First Middle Last

2. Please choose **ONE** of the following:

Graduated –  Year Withdrew –  Year Transferred –

3.

Information Requested: (Please choose all that apply)

\_\_\_\_\_ Transcript QTY: \_\_\_\_\_

\_\_\_\_\_ SAT/ACT Scores

\_\_\_\_\_ Health Record/Immunizations

\_\_\_\_\_ Report Card

\_\_\_\_\_ EOG/EOC Scores

\_\_\_\_\_ Other

(Please specify) \_\_\_\_\_

Reason for Request:

\_\_\_\_\_ College/University

\_\_\_\_\_ Withdrawal

\_\_\_\_\_ Employment

\_\_\_\_\_ Other

(Please specify) \_\_\_\_\_

4. Please choose one of the following delivery options: **Please allow up to 5 business days to process your request.**

Pick-up in Front Office

Mail To: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. I give permission for \_\_\_\_\_ to pick up my record request.

First and Last Name

By my signature below I give consent to the referenced records request.

\_\_\_\_\_  
Parent/ Guardian Signature  
(Parent Signature Required If Under 18)

\_\_\_\_\_  
Print Parent Name

Triad Math & Science Academy  
Attention: Registrar  
700 Creek Ridge Road  
Greensboro, NC, 27406 Phone : (336) 621-0061 Fax: (336) 621-0072