CONSENT FOR RELEASE OF RECORDS

Student's Full Name:		Birthdate:	
Grade Entering:	Entrance Da	ate to New Lothrop Schools:	
Current Address: _		City:	
State:	_ Zip Code:	Parent/Guardian's Name:	
Parent/Guardian Signature:		Date:	
School Transfe	erring From:		
	_		
City:	State: _	Zip Code:	
Phone Num	ber:	Fax Number:	
Please mail an	<u>y available reco</u>	ords to:	
	New Lo	othrop Elementary School	
	9387 Genesee Street		
	New Lothrop, MI 48460		
	810-638-5026		
		810-638-7289 fax	
Please fax the	<u>following inforn</u>	nation as soon as possible:	
☐ Transcript			
☐ Current IEP			
□ Other:			