SAINT COLUMBKILLE
PARTNERSHIP SCHOOL

Release of Records Request

Dear Parent/ Guardian,
Please complete and submit to the Saint Columbkille Partnership School Admissions Office.

Student name:_____Date of Birth:__________\ _____

Saint Columbkille Partnership School requests that you send all pertinent information, including:

- ✓ Academic evaluations and grade reports
- ✓ Record of attendance
- ✓ Record of discipline
- ✓ Record of core evaluations (IEP, 504 Plan)
- ✓ Health records

As the parent/guardian of the student named above, I give my consent for the above information to be sent to:

Saint Columbkille Partnership School
Attn: Admissions
25 Arlington Street
Brighton, MA 02135
Phone: 617-283-3109
Fax: 617-254-3161
Email: admissions@stcps.org

Additionally, I give my permission for school officials to share information requested by Saint Columbkille Partnership School.

I am requesting that records be sent from the following school:

School Name: _____

School Address: _____

School Phone: _____

School Fax: _____

Parent/Guardian Name: _____

Parent/Guardian Signature:_____ **Date:** _____