

Authorization for Release of Student Records

Date: _____ Applying for Grade: _____

Name of Student: _____ Date of Birth: _____

Name of School: _____

School Address: _____

City/State/Zip: _____

School Telephone Number: _____

Name(s) of Current Teacher(s): _____

Name & Title of Administrator(s): _____

I hereby give my permission to The King David School to contact my child's teacher(s) and/or school administrator(s) to discuss any issues pertinent to my child's application to The King David School.

I hereby authorize the release of all school records, educational and psychological, from my child's previous school(s) to The King David School.

All student records will be kept confidential.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Telephone Number(s): _____

Please send a copy of the complete transcript (including most recent report card), health records, test scores and other pertinent records to:

THE KING DAVID SCHOOL
12753 N. Scottsdale Rd.
Scottsdale, AZ 85254
FAX (480) 991-4115 / TEL: (480) 991-4333

mind. body. soul.

