



# GOLDENDALE SCHOOL DISTRICT REQUEST FOR STUDENT RECORDS

Date of Request \_\_\_\_\_

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Student Name (include middle initial)

Date of Birth

Grade

I hereby give my permission for **ALL EDUCATIONAL RECORDS** (achievement, behavioral, special education, and immunization) of the above-named child to be transmitted to the following school:

- GOLDENDALE PRIMARY SCHOOL** 820 S Schuster, Goldendale WA 98620 Ph 509-773-4665 F 509-773-6602
- GOLDENDALE MIDDLE SCHOOL** 520 E Collins, Goldendale WA 98620 Ph 509-773-4323 F 509-773-4579
- GOLDENDALE HIGH SCHOOL** 525 Simcoe Dr, Goldendale WA 98620 Ph 509-773-5846 F 509-773-6900

I understand my right to receive a copy of the records at my own expense, if requested, and to have an opportunity for a hearing to challenge content of the records. The information transferred will be treated in confidence and will not be transmitted to a third party without my consent as provided for in the Family Educational Rights and Privacy Act of 1974, as amended June 17, 1976.

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Signature of parent or legal guardian

## RECORDS REQUESTED FROM:

Name of School: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Contact Person: \_\_\_\_\_