LEGACY
KIDS CARE

STUDENT RECORD REQUEST RELEASE

INFORMATION TO BE RELEASED FROM:	INFORMATION TO BE RELEASED TO:
Name: **Legacy Traditional Schools**	Name: **Legacy Kids Care –** Please list campus name
School:	Title: **Admin and Staff**
Street Address:	Street Address:
City/State/Zip:	City/State/Zip:
Phone Number: Fax:	Phone Number:

Parent/Guardian would like the following records and/or information released to Legacy Summer Days:

_____ Health & Immunization Records

_____ Section 504 Plan Records

_____Psychological Evaluation Records

_____ Verbal Communication

_____ Special Education Records

_____ Written Communication

_____ Other: _____

Student Name	Date of Birth	Grade

I hereby authorize the school named above to release information, both verbally and in writing, to Legacy Summer Days.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of LKC Official Date