ARCHBISHOP RYAN HIGH SCHOOL

Office of Academic Affairs

Release of Records Form

In accordance with the Family Rights and Privacy Act, it is necessary for us to have written consent in order to release pertinent school and medical records.

Name of Student _____ Grade_____

Address _____

City _____ State _____ Zip_____

Signature of Parent/Guardian _____

To the Principal of _____
(Name of School)

Address _____

City _____ State_____ Zip _____

Please us a transcript of the credits, discipline records, medical records and immunization records for:

Name of Student _____ Date of Birth _____

Who was enrolled in your school and is now applying for admission to:

Archbishop Ryan High School
11201 Academy Road
Philadelphia, PA 19154