

**ADLAI E. STEVENSON HIGH SCHOOL**

**AUDIT REQUEST**

NAME \_\_\_\_\_ ID NUMBER \_\_\_\_\_ GRADE \_\_\_\_\_

COURSE NAME \_\_\_\_\_ SEM 1 SEM 2

REASON FOR REQUEST

- Students must speak with their counselor prior to making an appointment with the director to discuss the audit request.
- Students must return the completed form to their counselor for final approval by the 10<sup>th</sup> day of the semester.
- The counselor will e-mail notification of the final approval to the teacher and data processing.
- Audited classes do not apply toward an athletic or academic waiver for physical education.

STUDENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

TEACHER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
Recommend: Yes/ No

DIRECTOR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
Approve: Yes/No

COUNSELOR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**FOR OFFICE USE ONLY: Processed on \_\_\_\_\_ Initials \_\_\_\_\_**

**Electronic cc:**

**Student**

**Data Processing**

1/14 sp