Bridgewater-Raritan Regional High School
Department of School Counseling
600 Garretson Rd, P. O. Box 6569, Bridgewater, NJ 08807-0030
Phone (908)231-8660 Fax (908) 253-9480

GRADUATE TRANSCRIPT/IMMUNIZATION RECORD RELEASE FORM

PLEASE PRINT: Date: _____

LAST NAME **FIRST NAME** **MI** **MAIDEN NAME**

If you graduated/withdrew prior to 1992, please check East or West:

☐ Graduated _____ (Year) ☐ East ☐ West

☐ Withdrew _____ (Year) ☐ East ☐ West

Phone number where I can be reached: _____

I hereby authorize my transcript to be released to the address below. If transcript is being mailed to a college/ university, **PLEASE INCLUDE COLLEGE/UNIVERSITY NAME AND FULL ADDRESS**. One (1) college/university per form.

☐ Please include a copy of my immunization record with my transcript.

☐ I only need a copy of my immunization record mailed to the above address.

☐ Please email me a copy of my immunization record. My email address is:

_____ (PLEASE PRINT CLEARLY)

NO FEE

(Please allow 3 days prior notice. For transcripts prior to 1983, please allow 5 days prior notice.)

If you want your transcript mailed, please send this completed form to:

Patti Imbriani, Main Counseling Office
Bridgewater-Raritan High School
600 Garretson Rd, PO Box 6569
Bridgewater, NJ 08807
pimbriani@brrsd.org
908-231-8660 Ext. 2210

_____
Signature of Student

Main Counseling Office Use Only Date Mailed: _____