

**LAMPETER-STRASBURG SCHOOL DISTRICT**

1600 Book Road  
P. O. Box 428  
Lampeter, PA 17537  
Phone: (717) 464-3311  
Fax: (717) 464-4699

**CONSENT TO DISCLOSE RECORDS**

STUDENT'S NAME:

DATE OF BIRTH:

CURRENT GRADE:

I, parent/guardian of the above student, give permission for the following records to be released

to and from:           Lampeter-Strasburg School District  
                                  1600 Book Road  
                                  P. O. Box 428  
                                  Lampeter, PA 17537

to and from:

Records to be disclosed are:

Medical/Dental Records

Current ER/IEP/NOREP

Psychological Records

Standardized Test Results, PSSA Scores

Transcripts/Grades

Phone Contact

SAM Test (High School)

The reason the records are requested is:

I understand that I have the right to inspect and receive a copy of said records via a conference.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian