

TRANSCRIPT REQUEST

To request a copy of your transcript and medical records, please mail a copy of this form with a \$5.00 check or money order to:

Lisbon David Anderson Jr / Sr High School
Attn: Guidance Department / Transcript Request
260 W. Pine Street
Lisbon, Ohio 44432

I request that a copy of my transcript be sent to the following:

Name / College _____

Address _____

City, State, Zip _____

Colleges will only accept OFFICIAL transcripts. Transcripts must be received in a sealed envelope with the school seal. If you would like a copy for your records, this would be considered UNOFFICIAL.

Personal Information:

Students Name _____

Last Name

First Name

Middle Initial

Maiden Name _____ Date of Birth _____

Graduation or Withdrawal Date _____

Please specify the type and number of transcripts needed:

_____ Official Transcript _____ Unofficial Transcript

I understand that there is a \$5.00 fee for each transcript request. Please make check or money order payable to Lisbon David Anderson Jr/Sr High School.

Signature _____ Date _____

Telephone Number (_____) _____

(Office Use Only)

Date Fee Paid _____ Check No _____ Cash _____

Date Transcript Mailed _____