Medical Record Request Form

Student information:

(Please Print)
Last name while attending Leyden: _____

First name: _____

Last name (current): _____

Birthdate: _____

Phone number: _____

Email: _____

Date of graduation or last year attended: _____

Campus (circle campus attended) East or West or other_____

Address to mail health record to:

Name: _____

Institution: _____

Address: _____

City: _____ State:_____ Zip: _____

Email: _____ Fax: _____

Records can also be picked up in the health office during school hours.

Remember: A copy of your driver's license or state ID is required

Signature: _____ Date: _____
I authorize Leyden High Schools to release my medical records to the above recipient.