REQUEST FOR TRANSCRIPT/HEALTH RECORDS

Grand Island High School

Name_____ Today's Date _____

Maiden Name _____ Date of Birth_____

Year of Graduation _____ or Year of Withdrawal _____

Student Signature Required _____

Student Phone Number _____

Address for transcript mailing:

Name: _____

Street: _____

City: _____

State: _____ Zip code: _____

Are you requesting an official transcript? Yes _____ No _____

Are you requesting an unofficial transcript? Yes _____ No _____

Are you requesting Health Records? Yes _____ No _____

Hand Carried: Yes _____ No _____

Health Records are only on file for ten years after eighteenth birthday.