

SPOTSWOOD HIGH SCHOOL

EXCELLENCE IN EDUCATION

Transcript Request

Student's Name: _____

Current Name: _____
(If name from above has changed)

Date of Birth: _____

Current Address: _____

Telephone Number: _____

Email Address: _____

Year of Graduation: _____

If a Non-Grad,
Year of Withdrawal: _____

****A MINIMUM PROCESSING TIME OF 48 HOURS IS REQUIRED****
*****THERE IS A \$5.00 PROCESSING FEE FOR EACH TRANSCRIPT*****

- ☐ Please mail copies of my unofficial transcript
- ☐ Please mail copies of my official transcript (Official copies can only be mailed to your college or institution)
- ☐ Enclosed is the \$5.00 processing fee

TRANSCRIPT TO BE SENT TO:

Name: _____
(of College/Company/Institution)

Address/email to send to: _____

Student's Signature: _____ Date: _____

Parent/Guardian
Signature: _____ Date: _____
(If under 18 years of age)

Mail/Fax/Email Information:

Spotswood High School
School Counseling Services Department
105 Summerhill Road
Spotswood, NJ 08884
Fax # (732) 251-7666 or Email: ddellaglio@spsd.us