



Records Release Request

Name of Previous School: _____

Address: _____

City _____ State _____ Zip Code _____

Phone: _____ Fax: _____

I give permission for the release of information on:

Name of Student: _____ **DOB** _____

Schools must have written permission from the parent or eligible student in order to release any information from a student's educational record.

Please send all educational documentation including, but not limited to, the following:

- **Transcripts**
- **Attendance Records**
- **Discipline Records**
- **Standardized Test Scores**
- **Current Special Education Evaluation**
- **Current Individualized Education Plan**
- **Current Placement/Grade Level**
- **ALL Health Records**

Please send the requested information to the following:

Logos
Attn: Admissions Department
CC: Records Department
9137 Old Bonhomme
St. Louis, MO 63132
Phone: (314) 997-7002
Fax: (314) 997-6848

Parent/Guardian Signature

Date