

MATER DEI HIGH SCHOOL

\$5.00 PER DOCUMENT

TRANSCRIPT/HEALTH RECORD REQUEST

I, _____ (Maiden Name) _____ hereby
consent to the release by Mater Dei High School a copy of my records to the following:

Date of Birth: _____ Year of Graduation: _____

Institution/Employer:

Mailing Address:

(Street Name and Number)

(City, State, Zip Code)

Signature: _____

Date of Request: _____ Arrangements: _____

Date Received _____

Date Processed _____

Date Paid _____

Processed by _____

Initial Contact Information _____ Make checks payable to: Mater Dei High School
Revised 8/23/10