TRANSCRIPT / HEALTH RECORD REQUEST

$5.00 PER DOCUMENT

YOUR REQUEST WILL BE PROCESSED WITHIN TWO WORKING DAYS OF RECEIPT

PLEASE MAIL TO MATER DEI HIGH SCHOOL
1300 HARMONY WAY
EVANSVILLE, IN 47720

DATE ____________________

I, ____________________________________ Maiden Name _________________________

Date of Birth____________Year of Graduation ___________Day Phone #____________

Address ______________________________________

City _____________________ State ___________ Zip______________

Hereby consent to the release, by Mater Dei High School, a copy of my

- o Health Record
- o Transcript

to the following:

- o Myself Pickup________ Mail __________
- o Other (pickup) ___________________________________
- o Mail to Institution/Employer

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Address ____

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Signed ____

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Date Received ___________ Date Processed _______ By ____________

Paid: Cash ___________ Check #____________ Make check payable to: Mater Dei High School

Receipt #_________________