AUTHORIZATION TO RELEASE SCHOOL TRANSCRIPT

Authorization is hereby granted to Forsyth Public Schools to release permanent transcript records of:

_____

Full Name at time of graduation (Please print or type)

_____

Year of graduation from Forsyth High School

Please release the records to the following address:

_____

Name

_____

Complete Mailing Address

_____

City State Zip

_____ _____

Date Signature

RETURN SIGNED FORM TO:

Forsyth High School
Box 319
Forsyth, MT 59327
FAX: 406-346-9219
EMAIL: tbrown@forsyth.k12.mt.us

FOR OFFICE USE ONLY:

Transcript sent on _____

Date

By: _____

Authorized Name or Initials

Revised 9-14