MOUNTAIN GROVE R-3 SCHOOLS

REQUEST FOR TRANSCRIPT

NAME: ________________________________ DATE OF BIRTH: __________________

NAME UNDER WHICH I WAS ENROLLED: ___________________________________

DATES OF ATTENDANCE: ______________ DATE OF GRADUATION: ______________

CURRENT ADDRESS: ____

____

PHONE NUMBER: ____

MAIL TRANSCRIPT TO: ____

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FAX TRANSCRIPT TO: ____

FAX NUMBER: ____

I understand that no individual or agency outside of the school district will be permitted to inspect or receive my school transcript without my permission.

Parent permission requested if student is under the age of 18.

SIGNATURE: __________________________________ DATE: ___________________

Please mail or fax transcript request form to Mountain Grove Schools, P.O. Box 806, Mountain Grove, MO 65711. Fax #: 417-926-4564.