Sky View Middle School

63555 NE 18th St
Bend OR 97701
Main Office (541) 355-7600
Fax (541) 355-7610

REQUEST FOR STUDENT EDUCATIONAL RECORDS

Date: ______________________ Second request date: ______________________

To: School Principal or School Records Custodian at:

Last School or Program Attended (name): ______________________

School Address: ______________________

City, State, Zip Code: ______________________

If the student was scheduled to attend a high school or middle school for the first time, list this school name.

The student listed below has enrolled in our school. To assist with academic placement and planning we are requesting the following:

_____ Please mail all cumulative educational records including special education, medical, behavioral, confidential, withdrawal grades, grade reports, test scores, transcripts, and any additional educational records.

_____ Please fax a Special Education Eligibility Statement, current IEP and Psych and Speech Evaluation reports.

_____ Please fax immunizations, transcript or recent report card and withdrawal grades to the fax number listed below.

Student Name	Date of Birth	Grade	Home School, Online School, Other Program Enrolled? *If yes, please provide a program name and location.*
			___ No ___ Yes ______________
			___ No ___ Yes ______________
			___ No ___ Yes ______________

Mail records to:

School Name: Sky View Middle School

Address: 63555 NE 18th St.
Bend OR 97701

Telephone: 541-355-7700

Fax: 541-355-7610

Thank you,
School Records Custodian: ______________________

This request is in compliance with federal and state laws, ORS 326.575 regarding the release of student records.