MONROVIA
COMMUNITY ADULT SCHOOL

920 South Mountain Avenue Monrovia, CA 91016

FAX TO 626-471-3036

AUTHORIZATION FOR RELEASE OF SCHOOL INFORMATION

I hereby authorize Monrovia Adult School to release my information to:

Name: _____

Address: _____

City: _____ State _____ Zip Code_____

Name of Student: _____ Date of Birth: _____

Records under different name: _____

Student Phone: ( ) _____ - _____

Information Requested Transcript: _____Other:_____

Date of Last Attendance: _____/_____/_____ **(Important)**

Program: Diploma: _____ Other: _____

Did you graduate? _____ If yes, what year? _____

_____ Date: _____/_____/_____
Signature of Student

Instructions:

Date Rcvd: _____/_____/_____

☐ **Will pick up on ___/___/___**
☐ **Mail to above address**