

# Student Record Release

To releasing school counselor at:

School Name	Date	
Address		
City	State	Zip Code
Phone Number	Fax Number	
Email		

Dear counselor:

My child(ren) listed below has (have) been withdrawn from your school. Please release their academic and health records to the following school. Thank you.

Student Name (last name first)	Date of Birth	Grade level at time of withdrawal

**Accepting School:**  
Light Christian Academy  
1450 Citrus Oaks Avenue  
Gotha, FL 34734  
P: 407-347-0504 F: 407-985-1558  
admin@mylcac.com

\_\_\_\_\_  
Signature of Requesting Parent/Guardian

\_\_\_\_\_  
Signature of Receiving Vice Principal