GREAT REVELATIONS ACADEMY

Request for Student Records

Date Requested	
Date Received	

Name of Previous School:

Street Address:

City: State: ZIP:

School Phone #: Fax #: Email:

Student's Information

Legal Name:

Birth Date:

Grade Level: Last date of attendance (approx.):

The student listed above has just enrolled at GREAT REVELATIONS ACADEMY. Please send copies of the following documentation and transcripts of work completed at your school.

The following records are hereby requested:

IEP RECORD
TEST RESULTS
HEALTH RECORDS
TRANSCRIPT OF GRADES TO DATE AND OTHER PERTINENT INFORMATIOM

Signature of Requesting School Representative:

Signature Title Date

PLEASE SEND THE FILE TO: GRA@GREATREVELATIONS.ORG OR MAIL TO:

Great Revelations Academy

6400 Miller Road

Dearborn, MI 48126

Phone (313) 254-4504 – Fax (313) 649-5353

Note: According to the Final Regulations- Family Education rights and Privacy Act (Buckley Amendment) dated June 17, 1976; it is no longer necessary to obtain written consent to release records. It states that school officials, including teachers within the educational system in which the students may intend to enroll, may receive a student's records without a written consent for such releases.