Monticello High School
School Counseling Department
1400 Independence Way
Charlottesville, Virginia 22902
Phone: 434-244-3110 Fax: 434-244-3109

DATE: _____ **Amount Paid**_____ **Cash/Check**_____

To protect the confidentiality of students, we ask that you sign the following statement permitting us to release cumulative record information.

I give Monticello High School permission to release a copy of my school transcript for my college (or scholarship) /employment application._____
(Student Signature)

Student Name_____ **Date of Birth**_____ **Date of Graduation** _____

School Counselor _____ **Email Address**_____ **Telephone Number**_____

DEADLINE DATE	**NAME OF SCHOOL**	**MAILING ADDRESS**	**MAILING DATE**

Any future request for mailing of transcripts duly initialed and dated by my son/daughter **may/may not** be acknowledged without further authorizations by me.

_____ _____

Student Signature **Parent Signature (if student is under 18 years old)**

This request must be given to the School Counseling Department Secretary 30 school days prior to the application deadline in order to process your student record within application timelines.

Date received_____ Release valid for one year.