Office Use Only:
Date Sent/Ready:
_____
Amt Paid:
_____

WILSON SCHOOL DISTRICT
Counseling Office
2601 Grandview Boulevard
West Lawn, PA 19609-1324
610-670-0180, Ext. 1131 or 4603

Graduates only

TRANSCRIPT REQUEST FOR:

_____
Last Name First Middle Maiden Name

Birthdate _____ Phone No. _____

Year of: Graduation _____ **OR** Withdraw Date _____

# of Transcripts Requested: _____	Mail Transcript To:
Unofficial	_____
Official	_____
Scholarship	_____

I hereby request and authorize the release of the following records to the individual, institution, or agency listed:

Check appropriate block(s) Academic Transcript (& SAT/ACT) Other _____

_____ _____
Student's Signature **Date**

A $1.00 fee is required for each transcript.
Please return this request form with your payment and mail to the address listed above.
(We do not accept email or fax requests)

Rev. 10/08