



Stafford Public Schools
Transfer of Confidential Student Information

Date: _____

Pursuant to the Family Educational Rights and Privacy Act ("FERPA"), I hereby authorize the Stafford Public Schools to release and/or obtain the following confidential records regarding my child for the purpose of _____.

Student Name:: _____
DOB:: _____ Grade: _____
Address: _____
City: _____ State: _____ Zip: _____
Parent / Guardian: _____
Phone Number: _____

Transferring To / From:

School: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax: _____

Transferring To / From:
Stafford Public Schools
District Registrar
16 Levinthal Run
Stafford Springs, CT 06076

Registrar: Emily Wallach
registrar@stafford.k12.ct.us
Phone: 860-684-2208 Extension 6 Fax: 860-684-5172

I hereby authorize an exchange of information:

____ All Records ____ Health/Medical Records
____ Cumulative File ____ Special Education/504/Related Services
____ Attendance Records ____ Other: _____
____ Discipline Records

I understand that the information to be disclosed is protected as an "education record" under FERPA, and that such information shall not be redisclosed unless permitted under FERPA. I further understand that the officer, employees, and agents of any party that receives protected information under FERPA may use such information only for purposes for which the disclosure is made. I also understand this authorization is valid for one calendar year. It will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent.

Signature of Parent or Guardian

Date

Print Name of Parent / Guardian