



RELEASE OF RECORDS

Applicant's Full Name: _____

Applicant's Birth Date: _____

Current School Name: _____

Current School Address: _____

Principal/Director's Name: _____

I authorize the release of my child's academic and health records to
THE SAUL MIROWITZ DAY SCHOOL-Reform Jewish Academy

I also give permission for representatives to visit, at a pre-arranged date and time, my child's pre-school or elementary school in order to observe him/her in a school setting. I understand that this information is considered confidential and will be used by the proper authorities for admission purposes only.

Please mail all records to:

**THE SAUL MIROWITZ DAY SCHOOL-Reform Jewish Academy
11411 North Forty Drive
St. Louis, MO 63131**

Parent Signature

Date