

TRANSCRIPT RELEASE REQUEST
GRADUATES
Please Print

Name _____

Date of Birth _____

Maiden Name (if applicable) _____

ID # (if current student) _____

Year of Graduation _____ Last year attended (if you did not graduate) _____ Phone _____

Number of transcripts requested _____ Check here if you will pick up _____

Mail transcripts to: **(School name and complete address – use other side if more space is needed)**

Student Signature _____ Date _____

Parent Signature (if student is under 18 years of age) _____

Mail, E-Mail, or Fax to: Registrar, Stow-Munroe Falls High School
3227 E. Graham Road
Stow, Ohio 44224

Phone 330.689.5225 Fax 330-689-5303
Email: st_leonardi@smfcsd.org