

# BERLIN PUBLIC SCHOOLS NEW STUDENT TRANSFER OF STUDENT RECORDS REQUEST

Name of Student: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

New Home Address: \_\_\_\_\_

TRANSFER RECORDS FROM (PLEASE COMPLETE ALL REQUESTED INFORMATION):			
<b>School:</b>			
<b>Street:</b>			
<b>City/State:</b>		<b>Zip Code:</b>	
<b>Phone #:</b>		<b>Fax #:</b>	
TRANSFER RECORDS TO:			
<input type="checkbox"/>	<b>Berlin High School</b> 139 Patterson Way Berlin, CT 06037 Phone: 860-828-6577 Fax: 860-828-2169	<input type="checkbox"/>	<b>Catherine McGee Middle School</b> 899 Norton Road Berlin, CT 06037 Phone: 860-828-0323 Fax: 860-828-0676
<input type="checkbox"/>	<b>Mary E. Griswold School</b> 133 Heather Lane Kensington, CT 06037 Phone: 860-828-6336 Fax: 860-829-2923	<input type="checkbox"/>	<b>Richard D. Hubbard School</b> 139 Grove Street East Berlin, CT 06023 Phone: 860-828-4119 Fax: 860-828-6324
<input type="checkbox"/>	<b>Emma Hart Willard School</b> 1088 Norton Road Berlin, CT 06037 Phone: 860-828-4151 Fax: 860-828-4178	<input type="checkbox"/>	<b>Special Education Department</b> Berlin Board of Education 238 Kensington Road Berlin, CT 06037 Phone: 860-828-6581 Fax: 860-829-0832 <b>(Transfer Special Education Records Only)</b>
<input type="checkbox"/> <b>TRANSFER ALL RECORDS</b> (includes all options listed below) <b>OR</b> <input type="checkbox"/> <b>TRANSFER ONLY THE FOLLOWING</b> (check all below that apply):			
<input type="checkbox"/> <b>Cumulative File</b> <input type="checkbox"/> <b>Health/Medical</b> <input type="checkbox"/> <b>Disciplinary</b> <input type="checkbox"/> <b>504</b> <input type="checkbox"/> <b>Special Education</b> <input type="checkbox"/> <b>Other</b> _____			

Pursuant to the Family Educational Rights and Privacy Act ("FERPA"), I hereby authorize the Berlin Public Schools to obtain confidential records regarding my child. 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 officers, 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.

By signing below, I agree that a photocopy of this authorization will be as valid as the original. This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying the physician's office in writing, but if I do, it will not have any effect on actions taken by the physician prior to receiving such revocation.

I understand that under applicable law, the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that my child's treatment or continued treatment with any health care provider or enrollment or eligibility for benefits with any health plan may not be conditioned upon whether or not I sign this authorization and that I may refuse to sign it. Any information received by the school pursuant to this authorization is subject to all applicable state and federal confidentiality laws governing further use and disclosure of such information.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Parent/Guardian

*To be completed by former school*  
Student's CT SASID: \_\_\_\_\_