

CATHOLIC CENTRAL HIGH SCHOOL

320 West View
Steubenville, OH 43952

Telephone: 740-264-5538

Fax: 740-264-5443

Release of Transcript

Date: _____

Fee: \$3.00

Name (Maiden) _____

Telephone: _____ Cell Phone: _____

Address _____

City _____ State _____ Zip _____

Date of birth ___/___/___ Year of Graduation: Class of _____

For the following reasons: (please check)

_____ Post High School Education

_____ Employer requesting information

_____ Other (please specify) _____

Please forward the information to:

College or Firm _____

Address: _____

Fax : _____

Further, in consideration of the release of such information, and records to the parties indicated herein, the undersigned hereby promise, release and forever discharge the Catholic Central administration, the Diocesan Superintendent of Schools, and any and all of their agents, employees and officials who furnish such information as requested herein from any and all manners of actions causes and claims for damages that might result from the release of such information as registered.

Signature (Parent/guardian signature required if under 18 years of age)