

# faithful beginnings

at St. Alphonsus Parish School

## RELEASE OF PRESCHOOL SCREENING

**Name of Student:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Preschool Screening Location:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**School that record information is to be released to:**

Faithful Beginnings at St. Alphonsus Parish School

7031 Halifax Avenue North

Brooklyn Center, MN 55429

Phone: 763-561-5101 Fax: 763-503-3368

Please release the Preschool Screening Records, Special Education Records and any other information, which may be helpful in planning and implementing the student's school program.

I, the undersigned, give permission for the release of information as designated above.

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Records sent by (Name and Title)