TRANSCRIPT / IMMUNIZATION REQUEST

NAME :_____ DATE: _____
Last First M.I.

MAIDEN NAME (if different from current name): _____

DATE OF BIRTH: _____

YEAR OF GRADUATION: _____ LEFT WCS (did not graduate): _____
Month / Year

PLEASE SEND: (Check all that apply): ☐ Transcript ☐ Immunization Record

MAIL TO: _____ HOLD FOR PICK UP ON: _____

_____

_____

~OR~

FAX TO: _____ FAX #: _____

PHONE: (during the day): _____ (in case we need to get a hold of you)

Please return completed form to: Warsaw Middle High School
Counseling Center
81 West Court Street
Warsaw, New York 14569

**For more information or if you have any questions, call the Counseling Center at 585-786-8000 ext 2106 **

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FOR OFFICE USE ONLY: Date Sent: _____