



Regional Institute for Scholastic Excellence

Release of Information

To be completed by parent/guardian and school

FROM:

Name of School or Agency _____

Address _____

City

State

ZIP

This form must be completed and submitted with original signatures before student records will be reviewed.

I hereby authorize the release of permanent and temporary file information, as well as other pertinent information regarding my child.
I further authorize RISE to allow the home school to meet with my child any time it is deemed necessary.

Student Name

TO:

Regional Institute for Scholastic Excellence
253 W. Joe Orr Road
Chicago Heights, IL 60411

Signature of Parent/Guardian

Date

Signature of School Official

Date