



## TRANSCRIPT REQUEST FORM

Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ Expected Graduation: \_\_\_\_\_ Present Grade: \_\_\_\_\_

Counselor's Name: \_\_\_\_\_

Student's Current School:

\_\_\_\_\_  
Name of School

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, ZIP

**Authorization to release school records and all test scores to The Georgetown School of Arts and Sciences:**

**Signature of Parent (if student is under 18):** \_\_\_\_\_

**Signature of Student (if age 18 or over):** \_\_\_\_\_

**Mail or Fax ALL requested documents to 1200 Highmarket Street, Georgetown, SC 29440, Fax: 843-589-9071**

TGS Office Use Only

Date request sent: \_\_\_\_\_

Date transcript received: \_\_\_\_\_