Today's date_____

TRANSCRIPT REQUEST FORM

(Please allow 2 weeks for processing)

_____ _____

Last Name First M. I. Social Security Number

_____ _____

Name/Names your records could be under Birth Date

_____

Current Address

_____

City State Zip

_____ _____

Last Semester Enrolled at SHS_____ Year of Graduation _____

I authorize release of my transcript

Signature of Student (Required)

_____ I will pick up transcript at the SHS campus
_____ Please mail transcript to:

_____

Name OR School Name

_____

Address

_____

City State Zip

Office Use Only

Date mailed: _____

Counselor's Office
Seneca High School
1110 Neosho Street
Seneca, MO 64865
Phone 417-776-2294 Fax 417-776-1907

Please use one of the following methods:

1. Fax request to 417-776-1907
2. E-mail request to ddurman@senecar7.com
3. Drop off request at the Seneca High School Counseling Office
4. The Counselor's Office will be closed the month of July