The *GAP* at GAHS
27 Wallace Road, Goffstown, NH 03045

Re: Name of Student: _____

Date of Birth: _____

The above-named student has enrolled in the Goffstown Adult Education Program. This student withdrew from your school on _____ . Please forward this individual's transcript and other pertinent academic records (IEP) so we can evaluate his/her credit status.

I hereby give my permission to have my academic records forwarded to the Goffstown Adult Education Program office at the above address:

Date: _____ Name: _____
(Please give maiden name, if applicable)
Student's current address: _____
_____
_____

Name and address of High School attended: _____
_____

In addition, the above-named student has disclosed to us that he/she received special education services while at your school. In order for us to provide appropriate instruction and to obtain necessary accommodations for this student, it is essential that we obtain his/her special education tests and records.

I hereby give permission for my educational and/or psychological testing records be forwarded to the Goffstown Adult Education Program office at the above address:

Date: _____ Name: _____
(Please give maiden name, if applicable)

Date: _____ _____
Director, Goffstown Adult Education Program