



REQUEST FOR HIGH SCHOOL TRANSCRIPT

Please fill in form COMPLETELY.

DATE: _____

ATTENTION: STUDENT RECORDS DEPARTMENT

I hereby give permission to release information from the file of:

FIRST NAME	MIDDLE:	LAST:	MAIDEN:
FULL ADDRESS			
CITY:	STATE:	ZIP CODE:	CLASS OF:

X _____
SIGNATURE ___Student ___Parent ___Guardian (Authorized signature valid for 18 months and is valid for Preliminary and Final Transcript)

Please FAX OR MAIL Preliminary transcripts to:

FAX: (417) 873-7990

Email: druryad@drury.edu

DRURY UNIVERSITY

ATTN: ADMISSIONS

900 NORTH BENTON AVE

SPRINGFIELD, MO 65802

Submit electronically through: Naviance, Parchment or Scoir

OFFICE USE ONLY

Student #: _____ Starting Date: _____ HS#: _____