PMHS ALUMNI

TRANSCRIPT or HEALTH RECORD REQUEST

ALLOW 2 WEEKS FOR PROCESSING

Date of request: ____________________

Name: ____

Name when you graduated: (if same please leave blank):____

Date of Birth: _______________________ Phone #: ______________________________________

Your Email Address: ____

Best form of contact: Phone: _______ Email: _______

Month and Year of Graduation (or Left School): ____

Alternative HS Student: Yes _____ No _____

OFFICIAL TRANSCRIPT: ________________ UNOFFICIAL TRANSCRIPT: ______________________

Include Immunization Records: Yes _____ No _____

Name and Address where transcript will be mailed:

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Number of Copies Requested ($5.00 Per Copy): ________

Payment Type: Money Order: _________ My School Bucks:_________