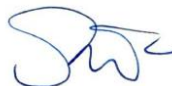


PARENT CONSENT FOR RELEASE OF INFORMATION

STUDENT NAME: _____

SCHOOL: _____

I authorize the following individual or organization to disclose my child's academic records as described below:

<i>Information to be received by:</i>	<i>Information to be released by:</i>
<u>The Campagna Center</u> Name of Professional or Agency <u>418 S. Washington St., Alexandria, VA 22314</u> Address <u>703-224-2361</u> Phone _____ Fax <u>Lizzie Liu, Director, Secondary and Adult Education Programs</u> Signature	Shanna Samson Office of Partnerships and Community Engagement <u>Alexandria City Public Schools</u> 1340 Braddock Place Alexandria, VA 22314 (703) 619-8152 shanna.samson@acps.k12.va.us  _____ Signature

I confirm that information and communication may be exchanged between parties for the purpose of developing student goals for improvement in the following areas:

- Academic Progress
- SOL Scores
 - Select Standardized Tests
 - Reading/Math Levels
 - Division Common Assessments (CRTs)
 - Grades
- Other (Please specify) _____

I consent to the release of the above information. I understand that use of this information for any reason other than the expressed reason stated above is prohibited and that disclosure of information to other parties is strictly prohibited. This consent is subject to revocation at any time.

My authorization will remain in effect for the entire academic school year 2019- 2020. .

I completed this form because I am: (please check one) Parent Legal Guardian

(SIGNATURE OF PARENT/LEGAL GUARDIAN)

(DATE)