



AVON HIGH SCHOOL COUNSELING DEPARTMENT

Alumni Transcript Request Form

Date: _____

Full name while attending AHS: _____

DOB: _____ Year of Graduation: _____ Phone Number: _____

I authorize the Avon High School Counseling Department to release my high school transcript to:

Name and address of individual or institution where transcript is to be sent:

Your Name (Printed)

Signature

Date

Please return this form to Avon High School via:

Fax: 860-404-4757 Attn: Jennifer King

Email: jking@avon.k12.ct.us

Mail: Avon High School
Counseling Department
510 West Avon Rd.
Avon, CT 06001

All alumni transcript requests will be processed within 10 school days of the receipt of this request.