



Alumni Transcript Request Form

Name: _____

Phone Number: _____

Maiden Name (if applicable): _____

Graduation Year: _____

Birth Date: _____

Current Address: _____

Send Transcript to: _____

By signing this form, I give Archbishop Carroll High School the permission to release my transcript: _____ Date: _____

There is a \$5 Processing Fee to mail transcripts within the United States. The International Processing Fee is \$10. Make checks payable to Archbishop Carroll High School. Mail this completed form with payment to:

Archbishop Carroll High School

Attn: Guidance Office

4524 Linden Avenue

Dayton, Ohio 45432