

TRANSCRIPT REQUEST  
PARKVIEW HIGH SCHOOL

Students Name: \_\_\_\_\_

Maiden or Other Name(s): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Year graduated: \_\_\_\_\_

I am requesting a copy of my:

Transcript to be mailed to the Education Institute/employer listed below

Transcript to be mailed to the students address listed below

Choose one:  Include ACT/SAT scores     Do not include ACT/SAT scores

Send copy of transcripts to:

School: \_\_\_\_\_

Attention: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Attached is \$2.00 (Cash or Check: made payable to Parkview High School)  
in payment of the Transcript fee.

**NOTE: Graduates will not be required to pay transcript fee within a year of graduation date.**

\_\_\_\_\_  
Student signature

\_\_\_\_\_  
Date

Phone number: \_\_\_\_\_

Mail to:    Registrar  
             Parkview School District  
             P.O. Box 250  
             Orfordville, WI 53576

**FOR REGISTRAR USE**

Date received: \_\_\_/\_\_\_/\_\_\_

Method of payment \_\_\_\_\_

Amount: \$ \_\_\_\_\_

Date sent: \_\_\_/\_\_\_/\_\_\_

**APPROVED:**    November 15, 2010  
                         **AUGUST 17, 2015**