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: _____

Month and Year of Graduation
(or left school): _____

Alternative HS student: Yes ____ No ____
(Night School)

Phone #: _____

OFFICIAL: _____ UNOFFICIAL: _____

Include Immunization Records: Yes ___ No ___

* Call for pickup _____

OR

Name and Address where transcript will be mailed:

_____

_____

_____

_____