

**Byron High School
TRANSCRIPT REQUEST FORM**

Student Name: _____

Maiden Name: _____

Graduation Year: _____

Today's Date: _____

School/Business/Person to Receive Transcript:

 Name: _____

 Address: _____

 City, State, Zip: _____

Student Signature: _____

- Check this box if you would prefer to pick up the transcript from this office.
- Check this box if there are any other recommendations or forms that must be sent *by the counselor*.

Requests will be processed within 1 week of receipt

Please Mail, Fax, or Email to:

Byron High School
Guidance Department
696 N. Colfax St.
Byron, IL 61010

PHONE: 815-234-5491 ext. 228

FAX: 815-234-2045

EMAIL: grovesd@byron.ogle.k12.il.us