OSU Expanded Options Program
Student Waiver

Date: ___________________________   Expires: ___________________________
(Note: The expiration date is less than one year, usually the end of the current school year.)

Student Name (printed): ________________________________________________

School District: ___________________________ School: ___________________________

School XOP Contact Person: ________________________________________________

Phone: ___________________________ E-mail: __________________________________

I authorize the OSU Expanded Options Program (XOP) to disclose the following information to my School XOP Contact person:

   _X_ Information needed to admit and register me for OSU XOP classes.
   _X_ Information needed to determine my OSU XOP class schedule.
   _X_ Information needed to pay my OSU XOP tuition and fees.
   _X_ Information needed to determine my progress in my OSU XOP classes.
   _X_ Information needed to determine my final grades in my OSU XOP classes.
   ____ Other information as follows: ____________________________________________
   ____________________________________
   ____________________________________

The purpose of this disclosure is to provide information sharing between OSU and my school to facilitate my participation in the Expanded Options Program.

_______________________________________________  ___________________________
Student Signature                        Date

School: After completing this form, please retain the original and fax (541-737-6124) or mail a copy to: Joan Oakes, Extended Campus, 4943 The Valley Library, Corvallis, OR 97331-4504.