Request for Campus Edugence Access

User's First Name *Last Name* *School/Location* *Phone*

Position *Employee ID#* *AISD email address*

Explain why this individual needs CAMPUS access:

Principal Signature *Date*

STUDENT DATA CONFIDENTIALITY AGREEMENT

I am an employee of the Arlington Independent School District. I have requested and am being given access to student information as part of my job responsibilities. By my signature below, I acknowledge that I understand that this information is strictly confidential. I agree to protect the confidentiality of this information. I understand that I may receive requests for access to this information by using my password.

I acknowledge and understand that if I fail to protect this information and/or if I give access to the information, I will be subject to disciplinary action, up to and including termination. I also acknowledge and understand that I may be subject to legal action as allowed by state and/or federal law.

Signature *Date*

Scan completed form and send it as an attachment to Wes Thrush, gthrush@aisd.net