SCHODACK
CENTRAL SCHOOL DISTRICT

Continuing Education Registration

Please use a separate form for each course and each person. Payments may be combined. Make check or money order payable to **Schodack Central Schools** and mail to:

Continuing Education
Schodack Central School District
1477 South Schodack Road, Castleton, NY 12033

Course Title: ________________________________ **Tuition:** __________________

Name: ____

Address:____

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E-mail:________________________________ **Telephone:** _________________________

How would you like to be contacted in the event of a cancellation? (please circle one)

Email **or** **Phone**

WAIVER INFORMATION

In the event of an emergency, I authorize the staff, nurse, doctors and/or emergency personnel to administer first aid or care as necessary. I understand that the Schodack Central School District does not provide medical insurance for participants and that in the event of any injury requiring medical treatment and/or hospitalization will be paid for by my personal insurance.

Participant's Signature & Date: ______________________________________

All information must be completed before this registration can be processed. Please do not send cash through the mail