

**SCHODACK**  
**CENTRAL SCHOOL DISTRICT**

**Continuing Education Registration**

Please use a separate form for each course and each person. This form may be copied. 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

**Registration forms must be received by September 12, 2024.**

**Course Title:** \_\_\_\_\_ **Tuition Enclosed:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**E-mail:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**In the event of a cancellation you will be notified by the instructor via email.**

**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 this 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.*