

# SMITHTOWN

CENTRAL SCHOOL DISTRICT

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[dsavage@smithtown.k12.ny.us](mailto:dsavage@smithtown.k12.ny.us)



Student Name \_\_\_\_\_

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

Parent Cell # \_\_\_\_\_

Learner's Per \_\_\_\_\_

**Transfers between classes will not be permitted.**

When selecting  
lecture and  
driving

I would prefer

Monday

Monday

Monday/

I would prefer

Mon. 2:00

Mon. 3:30

Sat. 7:00-8:00

Sat. 8:30-10:00

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**\*\*Once a student's registration is complete, refunds will be issued according to the schedule of classes. The student must complete the schedule of classes by the deadline.**

I have read, understand and accept the responsibilities of the program.

Student Signature

I certify that I am the parent or legal guardian and I agree to participate in the Driver Education program. I understand the rights and obligations outlined in the program pages.

Parent's / Guardian's Signature