SCHOOL TRIP PERMISSION SLIP

Scofield Magnet Middle School
641 Scofieldtown Road, Stamford, CT 06903
(203) 977-2750

March 18, 2019

Departure Date/Time: **Tuesday, April 2nd at 9:45 AM**

Return Date/Time: **Tuesday, April 2nd at 1 PM**

Mode of Transportation: **Bus**

Contact Person at School: **Mr. Clayton 203-977-2750**

Please Return By: **Wednesday, March 27th**

Cost: **$7.00 for the movie OR $13.00 for movie & popcorn/drink/fruit snack**

Lunch: **Students will need to bring a bagged lunch as they will miss their scheduled lunch time.**

Please fill out the form below and return your advisory teacher no later than Wednesday, March 27th.

School: Scofield MMS

I hereby give permission for my son/daughter/ward_____
(student name)

to participate in visiting **Bow Tie Cinemas- Landmark** to see the movie, Five Feet Apart.

Parent/Guardian Signature _____

Date_____

Home Phone _____ Work/Cell Phone _____

Emergency Contact Person _____ Emergency Phone _____

Please indicate any particular medical problems (such as medications being taken or food allergies) or any other food restrictions that would need to be addressed.

_____

_____

I give permission for any medical treatment that may be necessary in case of an emergency.

Parent/Guardian Signature _____ Date _____