PICTON HIGH SCHOOL

Creating Opportunities Achieving Success

Faculty: **Learning and Support** Year: **7 to 12**

Name of excursion: **Homework Hub**

Venue: **Learning Hub at Picton High School** Date: **27th Feb to 29Nov 2018** Cost: **$0**

Transport: **N/A**

Uniform required: **Full School**

The school reserves the right to exclude any student from an excursion if they do not comply with the uniform expectations.

Organiser/teacher in charge: **Jocelyn Keller**

Emergency contact number: **(02) 46771242**

Reason for excursion: **To assist students with homework / classroom tasks / assignments**

Departure time and Location: **3.30pm- Tuesday / Thursday at Picton HS Learning Hub**

Time of return and location: **4.30pm- Tuesday / Thursday at Picton HS Learning Hub**

Proposal approved by Head Teacher: **Mrs O Tesoriero**

Please return permission note to Mrs J Keller when attending Homework Hub

Retain for your reference

✂..

Return to school

I give permission for ____________________________ of roll class _________ to attend the:

Homework Hub at Learning Hub at Picton High School on the 27th Feb to 29Nov 2018. Transport: N/A

Please note that students must have permission before they will be permitted to attend the Homework Hub in the Library at Picton High School. It will be running on EVERY Tuesday and Thursday.Parents must be responsible for transport from homework hub as it is not provided by the school.All students are to be collect at 4:30pm. Thank you

I understand that the Department of Education does not cover the cost of medical expenses incurred as a result of an accident or injury to my child.

I understand that my child will be excluded from this excursion if they are on suspension.

I give permission to the school and DoE to publish names and photographs of my child: YES NO

In case of emergency I may be contacted at this number: _____________________ I enclose: $ _______

Special needs of my child of which you may need to be aware *(please provide full details).*

☐ Anaphylaxis ☐ Epilepsy ☐ Asthma ☐ Other (please state) ___________________________

Medication: ____

Special Dietary Requirements: ____

Allergies: *(please tick)*

☐ Sun ☐ Grass/Dust ☐ Pollen ☐ Insect Bites

Allergy to the following medication: ____

Other (please state): ____

Medicare Number: __________________

Parent Signature: ________________________________ **Date:** ____________