

# Free Soccer Clinic

Hosted by HSE Girls Varsity Soccer Coach, Randy Sherman



## Girls

### Grades 6 - 11

### Every Tuesday

### Through March 5th

Clinic begins on 12/5. No clinic on 12/26 and 2/20!

Please wear flat shoes. Bring shin guards and water.

## HSW Main Gym

## Tuesday 7:15-9 PM

Email [fsherman@hhh.k12.ny.us](mailto:fsherman@hhh.k12.ny.us) to register

APPROVED FOR DISTRIBUTION  
DEC 08 2023

DR. PATRICK HARRIGAN  
SUPERINTENDENT OF SCHOOLS

**HALF HOLLOW HILLS CENTRAL SCHOOL DISTRICT  
OF HUNTINGTON AND BABYLON**



Debra A. Ferry, CAA  
Director of Athletics

**#3) Intramural Permission Waiver-Emergency form**

**HALF HOLLOW HILLS CENTRAL SCHOOL DISTRICT**

**Intramural Permission Waiver-Emergency Form**

Name: \_\_\_\_\_ Male or Female -Grade: \_\_\_\_\_ School \_\_\_\_\_  
(Circle One)

Address \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
(Street) (Town) ( Zip)

I am aware that my son/daughter, \_\_\_\_\_ is participating in the intramural program at Half Hollow Hills during the fall/winter/spring season. I am also aware that he/she must abide by the school policies and regulations. Therefore, my son/daughter has permission to participate in the intramural program activity of \_\_\_\_\_.

Please list any medical concerns of which we should be aware of: (Ex: Previous Concussion {date}, Asthma, allergies,

etc.) \_\_\_\_\_

Medications \_\_\_\_\_

**Emergency Contact Names/Numbers**

Name of Father/Guardian \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of Mother/Guardian \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Please indicate the name, address and phone number of a close family friend or relative who lives in the local area who can be contacted in case of emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone Number(s) \_\_\_\_\_ / \_\_\_\_\_

If an emergency arises during my absence, I want my child to be given any medical treatment deemed necessary by the examining physician.

Date \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

(Please Sign)

Student's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

(Please Print)

\*\*\*This form must be filled out completely in order to participate in any intramural activity. In the Act of Forgery the student will be removed from all intramural activities. If you have any questions you may contact the Athletic Director, (631)592-3065. Thank you.