Cromwell Chill/TOPSoccer MENTOR PERMISSION SLIP

Mentor's name: _____

Telephone number: _____

Address: _____

E-mail: _____

Birth date: _____

Emergency Contact's name: _____

Emergency Contact's telephone number: _____

Physician's telephone number: _____

Hospital preference: _____

Health problems or allergies: _____

_____

Dates Available to Mentor (See Mentor Activity Schedule for Dates)

_____

(Mentors who are most available will be chosen first).

I give my permission to have my child's picture used in newspaper articles, promotional videos and on television.
I will not hold the Cromwell Soccer Club liable for any injury that may occur while my child is a mentor for the Cromwell/TOPSoccer program. I give my permission to have medical care obtained for my child.

Parent's signature: _____

Date: _____

Please email this form to sher930@snet.net or return this form to:

Cromwell Chill Soccer Club, PO Box 1272, Cromwell, CT 06416.