



**Mineola Youth and Family Services**  
The Advisory Council for the Youth of Mineola, Inc.

450 Jericho Turnpike  
Mineola, New York 11501

**SOCCER CLINIC**

**Executive Director**  
*Cristina Balbo, LCSW-R*

Phone: 516-742-1715  
Fax: 516-747-5690

**Board of Directors**  
**Chairperson**  
*Roseann Buglione*

**Treasurer**  
*Linda Doerrbecker*

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**SEX:** \_\_\_\_\_ **BIRTHDATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **AGE:** \_\_\_\_\_

**HOME ADDRESS:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**Board Members**  
*John Coyne*  
*Linda Doerrbecker*  
*Peggy May*  
*Tony Lubrano*  
*Ernie Abbamonte*  
*Judge Robert Rosenthal*

**TELEPHONE** (\_\_\_\_) \_\_\_\_\_ **# YEARS AT CURRENT ADDRESS** \_\_\_\_\_

**RACE:** WHITE\_\_\_HISPANIC\_\_\_AFRICAN AMERICAN\_\_\_ASIAN\_\_\_  
AMERICAN INDIAN\_\_\_ OTHER\_\_\_\_\_

**SCHOOL:** \_\_\_\_\_ |  
**GRADE FOR FALL 2011:** \_\_\_\_\_

**IS YOUR CHILD CURRENTLY IN SPECIAL EDUCATION CLASSES: YES \_\_\_ NO \_\_\_**

**Honorary Board**  
**Members:**  
*Dr. Samuel Carpentier*

**HAS YOUR CHILD EVER PLAYED SOCCER BEFORE? \_\_\_\_\_ HOW MANY YRS? \_\_\_\_\_**

**REFERRAL SOURCE: SCHOOL \_\_\_\_\_ FAMILY/FRIEND \_\_\_\_\_**

**MAILINGS \_\_\_\_\_ OTHER \_\_\_\_\_**

**EMERGENCY PHONE NUMBER: (\_\_\_\_) \_\_\_\_\_**

**PERSON TO CONTACT IN AN EMERGENCY \_\_\_\_\_**

**DATE OF LAST PHYSICAL EXAMINATION \_\_\_\_\_**

**HAVE YOU USED SERVICES PREVIOUSLY: \_\_\_\_\_**

**IF YES, WHICH SERVICES \_\_\_\_\_**

**\*E-MAIL \_\_\_\_\_**

*We will be e-mailing all forms, fliers, and all information pertaining to the clinic.  
So please check your email daily for updates.*

## INDIVIDUAL CHILD INFORMATION SHEET

\_\_\_\_\_  
CHILD'S NAME

\_\_\_\_\_  
PARENT(S) FIRST AND LAST NAME

\_\_\_\_\_  
HOME TELEPHONE NO.

\_\_\_\_\_  
WORK TELEPHONE NUMBER (S)

\_\_\_\_\_  
EMERGENCY CONTACT PERSON  
(Relationship to Child)

\_\_\_\_\_  
EMERGENCY NUMBER

\_\_\_\_\_  
NAME OF RESIDING TOWN

Dear Parent or Guardian:

We are pleased that your child will be participating in the 2011 Soccer Clinic sponsored by Mineola Youth and Family Services. For your child's safety it is imperative that you know that your child must be dropped off and picked up by a parent or guardian. Please fill out the information below and return it to our office at 450 Jericho Turnpike, Suite 207 before your child begins the program. Please discuss with your child and check all of the boxes that apply to your child.

- I will be dropping my child off and picking my child up from the program. I will contact the office in the event of any circumstances change pertaining to this decision.
- I hereby give my permission for the following person(s) to pick up my child after the program concludes.

Name/Phone Number \_\_\_\_\_ Relationship to Child \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*If someone picks up your child besides you and is NOT written in the above space, they will NOT be released to that person.**

PLEASE NOTE IN THE SPACE PROVIDED BELOW WHETHER OR NOT YOUR SON/DAUGHTER HAS ANY LIFE THREATENING MEDICAL CONDITIONS OR ALLERGIES

MEDICAL  
HISTORY \_\_\_\_\_

ALLERGIES \_\_\_\_\_

DOES YOUR CHILD HAVE AN EPIPEN FOR HIS/HER ALLERGY

YES

NO

Dear Parents,

Often times the agency faces funding cuts at the local and state level. When this occurs, Mineola Youth writes letters to local and state legislators urging that they continue to maintain funding for youth programs in Nassau County. Signing below would assist us in our advocacy efforts. Attached is a sample of what the letter may include.

I, \_\_\_\_\_, hereby, give permission for Mineola Youth and Family Services to include my name and address on any letters that pertain to future funding cuts to Mineola Youth.

Please print clearly:

**Name** \_\_\_\_\_

**Address** \_\_\_\_\_

\_\_\_\_\_

**Telephone number** \_\_\_\_\_

**MINEOLA YOUTH AND FAMILY SERVICES**

**MEDICAL FORM**

Date: \_\_\_\_\_

Name of child: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Is your child taking any medications? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, please state reason: \_\_\_\_\_

Does your child have any health problems, which might affect his or her participation in activities?

YES \_\_\_\_\_ NO \_\_\_\_\_

If so, please explain \_\_\_\_\_

Does your child have any allergies? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, what are they? \_\_\_\_\_

It should be noted that the Soccer Clinic does not have a nurse on staff, therefore, medications must be given prior to attending the program or they must be self-administered.

If your child becomes ill and we can't reach a parent or guardian, please name a friend or relative who can be contacted:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

Do you have medical insurance for your child? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, does it include mental health coverage? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you have medical insurance for yourself and spouse? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, does it include mental health coverage? YES \_\_\_\_\_ NO \_\_\_\_\_

What is the name of your current insurance carrier? \_\_\_\_\_



## REGISTRATION ENROLLMENT FORM

*Each child enrolled in the Soccer Clinic will be charged a mandatory registration fee of **\$100 for supplies and overhead costs**. This will include a ball and a jersey for your child. This fee is due no later than 11/18/11.*

*Please know, if we do not receive payment of \$100.00 on the specific dates, your child **cannot** attend the soccer clinic.*

*If you have any questions about this, please feel free to contact us at 516-742-1712 X105.*

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Child Name \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Today's Date \_\_\_\_\_

Signature \_\_\_\_\_

Method of payment (check one)

Check \_\_\_\_\_ Money order \_\_\_\_\_ Cash \_\_\_\_\_

*Please make all checks out to Mineola Youth and Family Services.*

Please attach this form and your method of payment **before** November 18, 2011

Thank you!

**PARENTAL RELEASE**

This is to certify that my  
son/daughter \_\_\_\_\_ has permission to  
participate in any and all soccer clinic activities. I assume all risks and hazards incidental  
to such participation and I do hereby agree to hold harmless the staff of the Mineola  
Youth Soccer Clinic from any and all claims arising out of any injury to my child.  
Furthermore, this verifies that my child is up to date with his/her immunizations and is  
able to participate in all soccer activities. In the event of injury my permission is granted  
for treatment as required at the nearest medical treatment facility.

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Mineola Youth & Family Services**

**Soccer Clinic General Information for Parents**

**Winter 2011-2012 Session**

**Saturdays : Time TBA**

**All children should dress appropriate for weather since many sessions may be held in cold temperatures.**

**All children must have soccer cleats and shin guards which must be worn to every session.**

**Please ensure your child arrives 10 minutes prior to the commencement of each session to allow for attendance and an opportunity to speak with your coach.**

**All children are also expected to bring water and extra sweatshirt which they can keep in a backpack.**

**There are no lockers or storage devices on the field, therefore children are asked not bring valuables to the sessions.**

**Parents must be on-time to pick up their children. If parents are not on-time, the coach is instructed to contact the Coordinator and Director at Mineola Youth & Family Services.**

**Important Contact Information:**

<b>Alexandra Delfino</b>  <b>Coordinator</b>	<b>Cell (631) 662-0931</b>	<a href="mailto:Adelfino@mineolayouth.org">Adelfino@mineolayouth.org</a>	<b>Office: Monday-Friday</b>  <b>(516) 742-1715</b> <b>ext. 105</b>
<b>Spiro Tsirkas</b>  <b>Coach</b>	<b>Cell ( 516) 587-0249</b>	<a href="mailto:Spirotsirkas@yahoo.com">Spirotsirkas@yahoo.com</a>	

