



## Craig School Basketball Clinic (Permission Slip)

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_

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

(Please Print)

I have read the entire flyer concerning the Craig School Basketball Clinic and have discussed it with my child. I have also given my child, \_\_\_\_\_ my permission to attend the Craig School Basketball Clinic, and, hereby authorize Mr.Facendola and or a counselor to arrange for such medical attention for my child as he or she deems necessary in the event of illness or injury. **I agree to pick up my child at 7:00pm(Grades 5-6) and 8:00pm(Grades 7-8).**I also grant permission for my son/daughter to be photographed or video-graphed at the Craig School Basketball Clinic. Photographs/camera footage may appear in newspapers, magazines, newsletters, brochures, videos, or other forms of promotion, including the borough website.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Home Telephone# \_\_\_\_\_

Emergency Telephone# \_\_\_\_\_

**Please note: All children must be picked up. No child may walk or ride a bike home after the Basketball Clinic is over.**

