



Summer Satellite Program

Program Goals & Objectives:

Speed Training * Agility Training * Plyometric Training * Strength Training Guidance

Program Location:
 Family Wellness **West Central Athletes ONLY**

Session Times:

8 – 9:15 a.m. **9:30 – 10:45 a.m.**
(Athletes per session: Minimum - 8 / Maximum - 24)

Dates & Days:

June 8, 2009 – August 7, 2009
Monday, Wednesday, Friday

(Registration Deadline – June 1, 2009. Please contact the POWER staff if your registration will be delayed.)

Registration Fee: \$150

For more information call (605) 328-1660

(MUST BE A MINIMUM OF EIGHT (8) PER SESSION)

FAMILY WELLNESS – WEST CENTRAL ATHLETES ONLY

Name: _____ Phone: _____ Age: _____ Sex: **M F**
(Please Circle)

Address: _____ City: _____ ST: _____ Zip: _____

Session Times: _____ **8 – 9:15 a.m.** _____ **9:30 – 10:45 a.m.**

T-Shirt Size: **S M L XL XXL** *(Please Circle)*

Registration Fee: \$150 Mail to: Sanford POWER Center, 6320 S. Cliff Ave, Sioux Falls, SD 57108

Signature of participant, parent or guardian (if under 18)

Date

HEALTH QUESTIONNAIRE

- School/Occupation: _____
 - Sport/Interests: _____
 - Position(s) Played in Sport: _____
 - Birthdate: ____/____/____ 5. Height: _____ 6. Weight: _____
 - Clinic: _____ Phone #: _____
 - Doctor: _____
 - Have you ever been diagnosed with any of the following?

<input type="checkbox"/> Coronary Heart Disease	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic Heart Disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Heart Murmurs	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizures	<input type="checkbox"/> Angina
- Other, please explain: _____

Please fill out both sides of this form.

10. Do you have any of the following?

- Back Pain
 Joint, tendon, or muscular pain
 Lung disease (asthma, emphysema, other)



Please explain: _____

11. Have you experienced chest pain due to physical activity? Yes No
12. Have you experienced chest pain within the last month? Yes No
13. Have you lost consciousness or fallen due to dizziness? Yes No
14. Are you under a doctor's supervision for any illness or physical condition that may affect your ability to exercise? Yes No
Condition: _____
15. Are you pregnant? Yes No
16. Please list any medications you take on a regular basis: _____

I hereby consent to having my child/active adult participate in the POWER Athletic Enhancement program. I understand that there are risks involved in such participation and relinquish Sanford USD Medical Center & Sanford Wellness Center from all liability. If my child/active adult has a pre-existing injury or medical condition, a written clearance from our physician is required before my child/active adult can participate.

Parent's or Guardian's Signature (if under 18): _____

Home Phone: _____ Work Phone: _____

Athlete's Signature: _____

Active Adult's Signature: _____