Summer Satellite Program

Program Goals & Objectives:

Speed Training * Agility Training * Plyometric Training

Program Location:
Roosevelt High School – RHS Athletes Only

Session Times:

8 – 9:15 a.m. 9:30 – 10:45 a.m. 11 a.m. – 12:15 p.m.

(Athletes per session: Minimum - 8 / Maximum - 24)

Dates & Days:

June 2, 2008 – August 1, 2008

Monday, Tuesday, Thursday, Friday

(Registration Deadline – May 23, 2008. Please contact the POWER staff if your registration will be delayed.)

Registration Fee: $125

For more information call (605) 328-1611

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

ROOSEVELT HIGH SCHOOL

Name: ______________________ **Phone:** ______________ **Age:** ______ **Sex: M F** *(Please Circle)*

Address: ______________________ **City:** ______________ **ST:** ____ **Zip:** ________

Session Time: (Please rate sessions in order of preference)

___ **8 – 9:15 a.m.** ___ **9:30 – 10:45 a.m.** ___ **11 a.m. – 12:15 p.m.**

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

Registration Fee: $125 Mail to: Sanford POWER, 4201 S. Oxbow Ave., Sioux Falls, SD 57106

______________________________ ______________

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

HEALTH QUESTIONNAIRE

1. **School/Occupation:** ______________________
2. **Sport/Interests:** ______________________
3. **Position(s) Played in Sport:** ______________________
4. **Birthdate:** ____/____/____ 5. **Height:** ________ 6. **Weight:** ________
7. **Clinic:** ______________________ **Phone #:** ______________________
8. **Doctor:** ______________________
9. **Have you ever been diagnosed with any of the following?**

______**Coronary Heart Disease** ______**Heart Disease** ______**Rheumatic Heart Disease**
______**Stroke** ______**Congenital Heart Disease** ______**Epilepsy**
______**Heart Murmurs** ______**Diabetes** ______**Hypertension**
______**Cancer** ______**Seizures** ______**Angina**
______**Other, please explain:** ______________________

____

200-12900-0037 3/08

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:______________________