



Summer Satellite Program

Program Goals & Objectives:

Speed Training * Agility Training * Plyometric Training * Strength

Program Location:
Alcester-Hudson High School-Area Athletes

Session Times:

To be Determined

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

Dates & Days:

June 9, 2009 – August 6, 2009

Tuesday/Thursday

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

Registration Fee: \$175

For more information call (605) 328-1660

(MUST BE A MINIMUM OF 30 TOTAL ATHLETES)

ALCESTER-HUDSON HIGH SCHOOL

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

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

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

Registration Fee: \$175 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: _____

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: _____