



Summer Satellite Program

www.sanfordpowercenter.com

Program Goals & Objectives:
Speed Training * Agility Training * Plyometric Training

Program Location:
Brandon Valley High School – BVHS 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 8, 2009 – August 5, 2009
Monday, Wednesday, Friday
(Registration Deadline – June 1, 2009. Please contact the POWER staff if your registration will be delayed.)

Registration Fee: \$125
For more information call (605) 328-1660
(MUST BE A MINIMUM OF EIGHT (8) PER SESSION)

BRANDON VALLEY 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 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?

___ Coronary Heart Disease	___ Heart Disease	___ Rheumatic Heart Disease
___ Stroke	___ Congenital Heart Disease	___ Epilepsy
___ Heart Murmurs	___ Diabetes	___ Hypertension
___ Cancer	___ Seizures	___ 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: _____