Summer Satellite Program

Program Goals & Objectives:

Speed Training * Agility Training * Plyometric Training

Program Location:
Lincoln High School – LHS 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 7, 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)

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LINCOLN 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

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:** ______________________________

200-12900-0036 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:____