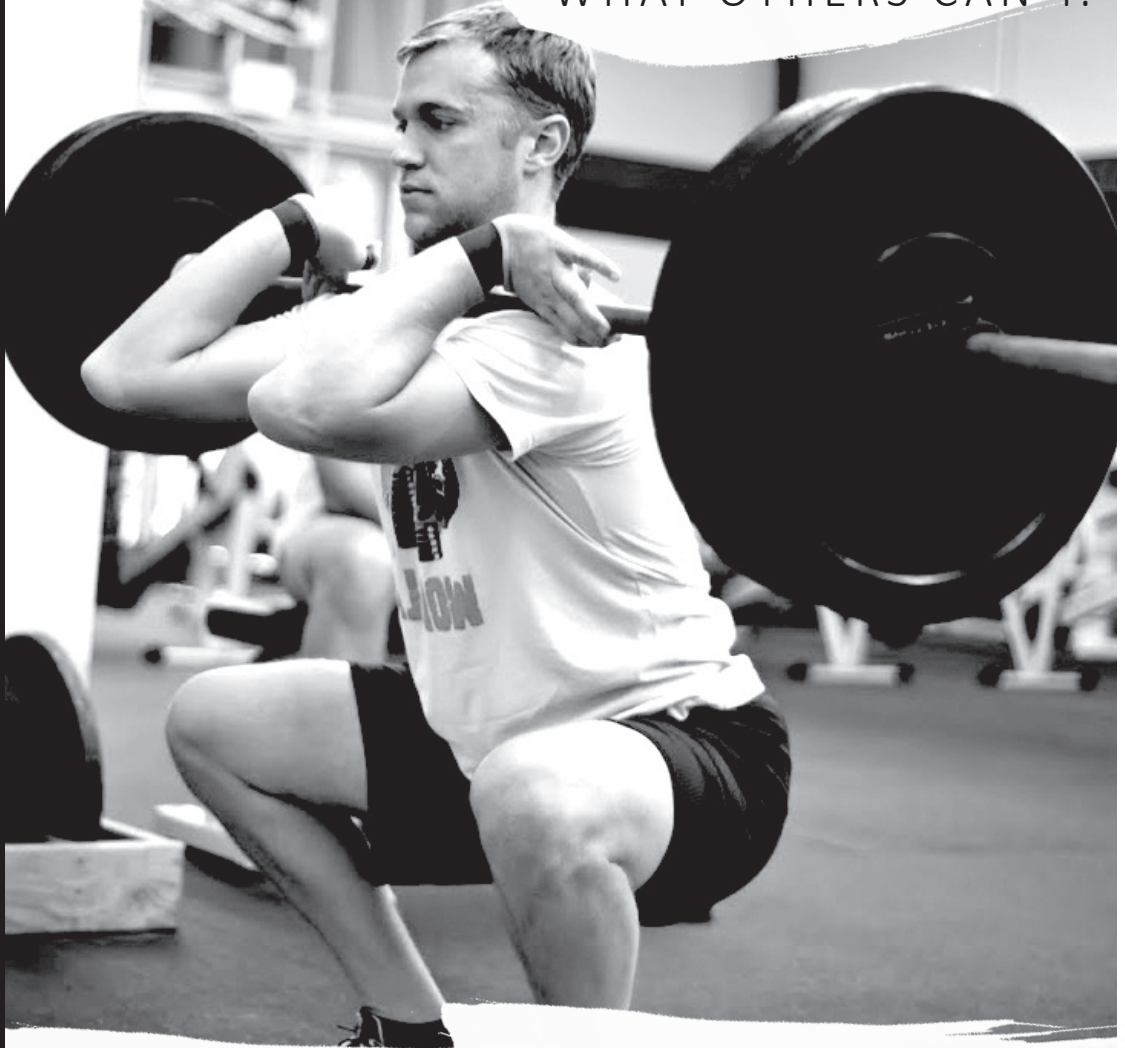


W I N D O M A R E A H E A L T H
POWER ACCELERATION
P R O G R A M

TODAY **I WILL DO** WHAT OTHERS WON'T,
SO TOMORROW **I CAN DO**
WHAT OTHERS CAN'T.



PROGRAM GOALS & OBJECTIVES:

- Speed Training
- Agility Training
- Plyometric Training
- Strength Training

PROGRAM LOCATION:

Windom Area High School

REGISTRATION FEE: \$130*

*(Fee includes weight room) *Family cap of \$260*

REGISTRATION DEADLINE: June 5

DATES & DAYS:

June 12–August 3

Mondays, Tuesdays and Thursdays

*No Sessions on Monday, July 3 or
Tuesday, July 4. There will be sessions
Thursday, July 6 and Friday, July 7.*

SESSION TIMES:

6:25–7:40 a.m. *(9-12 grades preferred)*

7:45–9:00 a.m. *(6-8 grades preferred)*



**WINDOM
AREA HEALTH**

Rehabilitation



QUESTIONS? Call Windom Area Health Rehabilitation at 831-0634.



Name: _____ Phone: _____ Age: _____ Sex: M F
 (Please Circle one)
 Address: _____
 City: _____ State: _____ Zip: _____

SESSION TIME:

_____ 6:25–7:40 a.m. (Grades 9–12 preferred) _____ 7:45–9:00 a.m. (Grades 6–8 preferred)

T-Shirt Size (Adult sizes ONLY): S M L XL XXL (Please Circle one)

Registration Fee: \$130.00* (fee includes weight room)*Family cap \$260.00

*****PAYMENT IS DUE PRIOR TO PARTICIPATION UNLESS
 OTHER PAYMENT ARRANGEMENTS HAVE BEEN MADE.*****

MAIL OR DROP OFF PAYMENT TO:
 Windom Area Health
 c/o Rehabilitation Department
 2150 Hospital Drive
 Windom, MN 56101

Signature of participant, parent or guardian (If under 18 years of age.)

_____ Date: __/__/_____
 (Signature)

HEALTH QUESTIONNAIRE:

1. Birth Date: __/__/____ Height: _____ Weight: _____

3. Clinic: _____ Phone #: _____ - _____ - _____

4. Doctor: _____

5. 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 |
| <input type="checkbox"/> Other, please explain: _____ | | |

6. 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 Windom Area Health POWER AND ACCELERATION program. I understand that there are risks involved in such participation and relinquish Windom Area Health and Windom Area Schools 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. I also give my permission for the free use of my child's name and/or pictures for publicity.

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

Home Phone #: _____ - _____ - _____ Work Phone #: _____ - _____ - _____