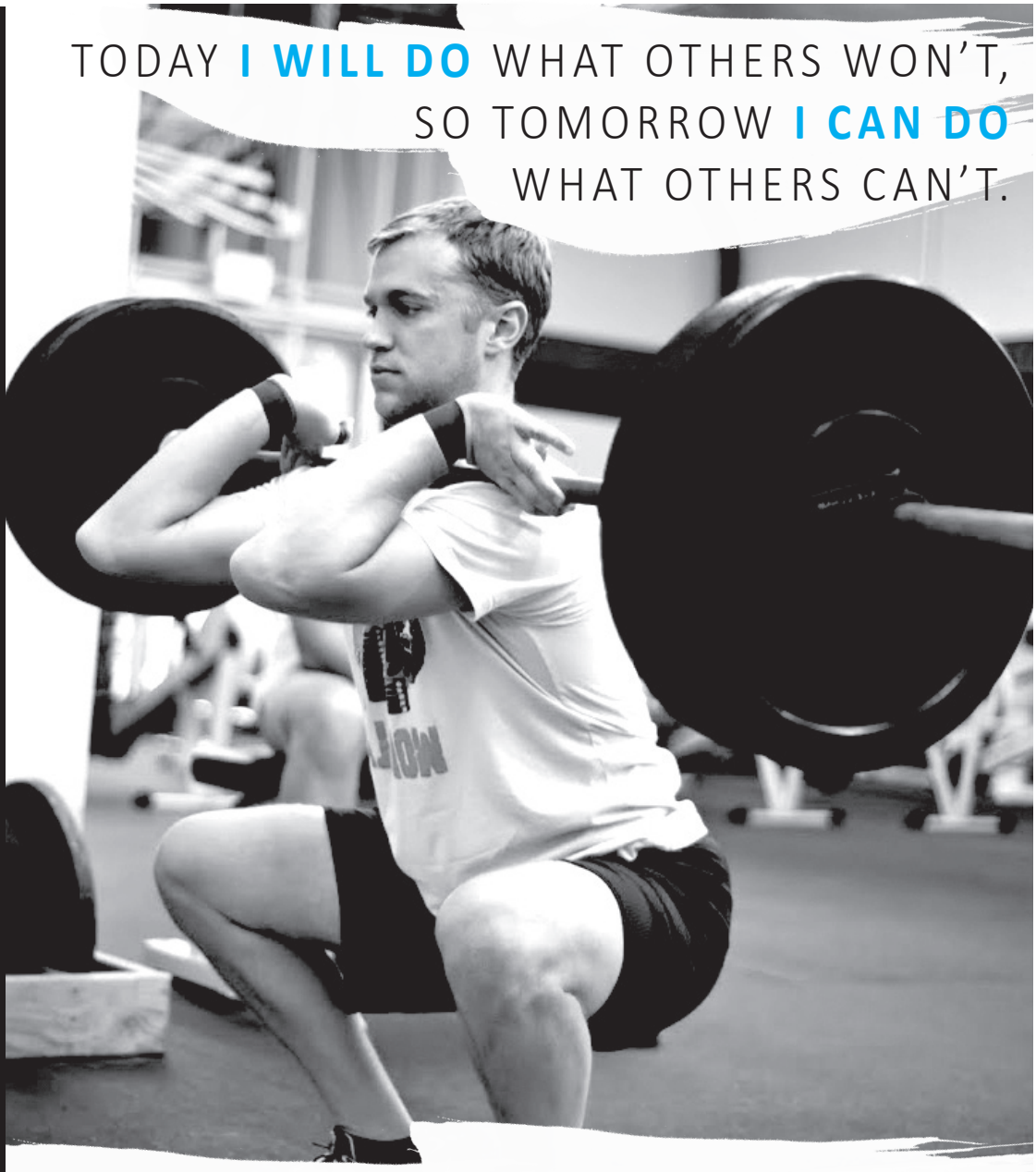
WINDOM AREA HEALTH POWER AND ACCELERATION PROGRAM

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 7

DATES & DAYS:
June 10–August 1
Mondays, Tuesdays and Thursdays

Please Note: There will be no sessions on Thursday, July 4.

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.

WINDOM AREA HEALTH

POWER AND ACCELERATION PROGRAM

WINDOM AREA HEALTH Rehabilitation

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?

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

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