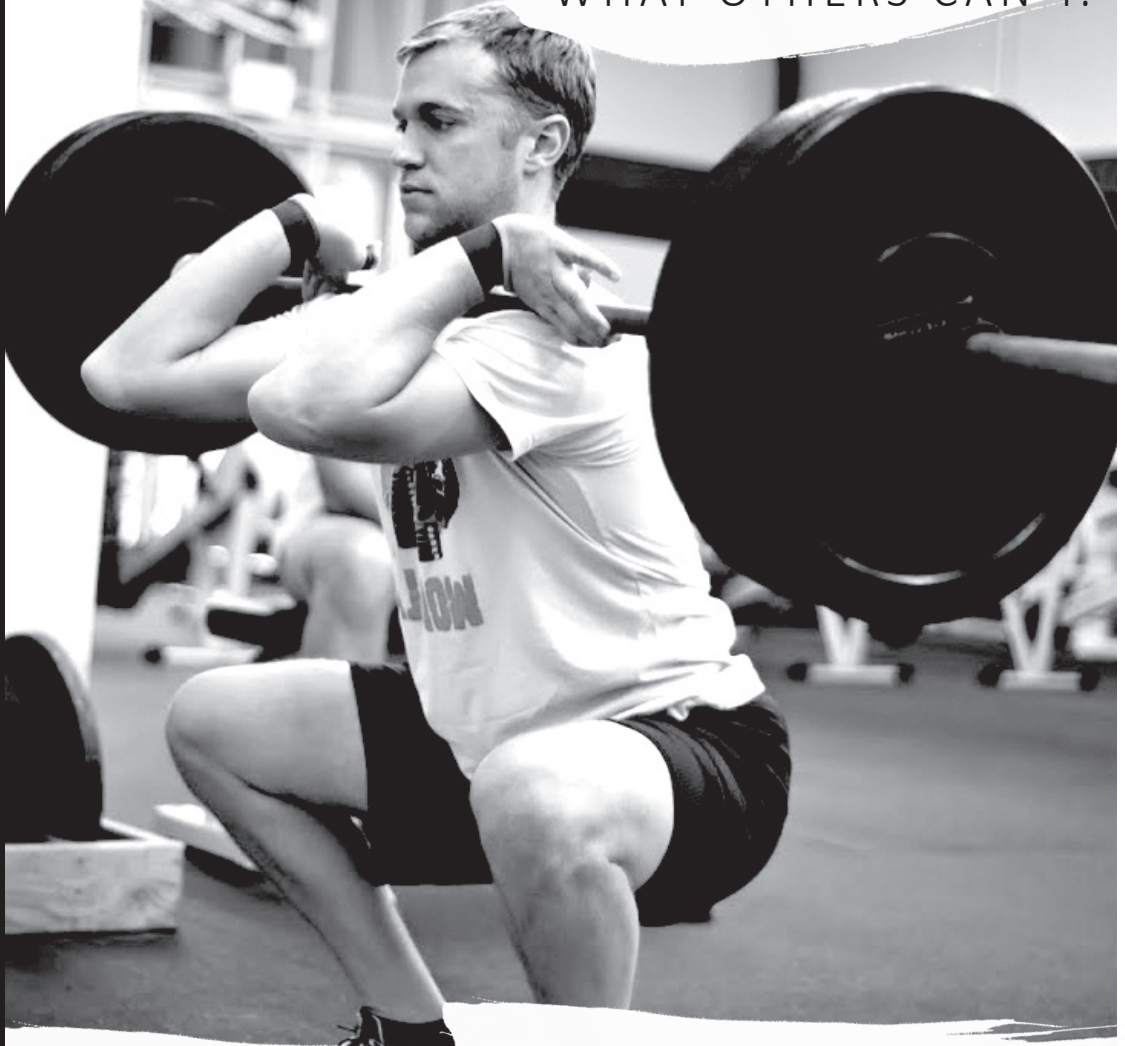


W I N D O M A R E A H O S P I T A L
POWER AND ACCELERATION P R O G R A M

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: \$120

(Family cap of \$240, includes weight room)

REGISTRATION DEADLINE: June 1

DATES & DAYS:

June 11–August 10

Mondays, Tuesdays and Thursdays

No POWER the week of July 4th

SESSION TIME:

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

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

9:00-10:15 a.m. *(if needed)*


Windom Area
Hospital



WINDOM AREA HOSPITAL POWER AND ACCELERATION PROGRAM



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

Session Time: (Please rate sessions in order of preference)

_____ 6:25 - 7:40 a.m. _____ 7:45 - 9:00 a.m. _____ 9:00 - 10:15 a.m. (if needed)
(9-12 grades preferred) (6-8 grades preferred)

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

Registration Fee: \$120 Mail to: Windom Area Hospital Rehabilitation Dept., 2150 Hospital Dr, Windom MN, 56101
(Family cap \$240, includes weight room.)

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?

- | | | |
|---|---|--|
| <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: _____ | | |

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 Windom Area Hospital POWER AND ACCELERATION program. I understand that there are risks involved in such participation and relinquish Windom Area Hospital 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.

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

Home Phone: _____ Work Phone: _____

Athlete's Signature: _____

Active Adult's Signature: _____