Hockey FASTER

Flexibility, Agility, & Strength Together Equal Ready

Who is eligible? Hockey players grade 5 to seniors for fall 2019

HIGH SCHOOL FASTER HOCKEY Cost=$250 if registered by May 10th, then fees increase $15

Two days per week dryland FASTER hockey training with Kevin Melby at MAYSA Arena Trinity Dryland room for injury prevention programing **AND** Two days per week strength training with programming specific to the needs of the hockey athlete. Program Mon-Thurs 7 am-8 am

Hockey Booster two option package

- FASTER Mon/Wed ($150 if by early bird deadline) 8 am-9 am
- FASTER + hockey specific lifting Tue/Thurs ($250 if by early bird deadline) 8 am-9 am

Hockey FASTER program design

1. **Hockey Specific dynamic warm-up**
2. **FASTER injury prevention dryland designed specific to injuries commonly seen in the hockey athlete.**
3. **Balance and Agility training specific to the demands of hockey, including utilizing hockey stick handling in dryland training**
4. **Focus on increase in single leg strength and vertical jump which directly correlates to skate speed**
5. **Weight lifting session designed specific to the bodies demands needed for hockey**

Sign up deadline May 22th! Fees increase $15 after May 10st. Contact Kevin Melby at the Maysa Sports Medicine Center at (857-2016) or Robyn Gust at Trinity Sports Medicine (857-3486) for more info.

Name _____ Phone _____

Email_____ T-shirt Size XXL XL Lg Med SM

I am entering grade _____. Please check Male _____ Female _____

CHOOSE OPTION: _____**High School FASTER Mon-Thur 7 am-8 am**

Hockey Booster options _____ **FASTER Only (Mon/Wed) $150 8am-9am**

_____**FASTER +Lift (Mon-Thur) $250 8 am-9am**

Circle Minot High Time: **Boosters** Mon/Wed 9:30am **High School** Tu/Th 6:30am 8:00

Return forms to Maysa Sports Medicine Center or send to Sports Medicine 101 3rd Ave SW, attn Robyn

Needed to complete application: Application form Medical History Waiver Check to Trinity

Trinity Health Waiver, Release of Liability, and Consent

For and in consideration of being permitted to participate in the programs and services of Trinity Health (herein "TH"), the sufficiency of such consideration being acknowledged, I for myself, my heirs, successors, representatives and assigns, hereby now and forever RELEASE, ACQUIT, and DISCHARGE "TH" and its agents, employees, officers, directors, parent companies, subsidiaries, successors and assigns of and from any and all claims, demands, actions, remedies, causes of action, liability, damages, costs (including reasonable attorney fees), expenses and losses of every kind of nature, whether at this time known or unknown, anticipated or unanticipated, direct or indirect, which I for myself, my heirs, successors, representatives and assigns now have or may have in the future by reason of my use of the facilities, whether caused by the acts or omissions of the "TH" or its employees, agents or representatives, or by any other person or persons.

I further understand and acknowledge, and hereby assume, the risks and hazards which may cause injury, disability and death, and perhaps damage to or loss of my property while on the premises or while participating in any or all activities conducted. Moreover, I hereby acknowledge that my use is voluntary.

Further, although I recognize that no duty to do so exists or is hereby created, nevertheless, in the event that I sustain any personal injury or require medical attention either before, during or after exercise or participation in any and all activities, I specifically authorize "TH" and its agent or employees to voluntarily and gratuitously perform onsite treatment for injury or medical condition. I understand that any on-site treatment will not necessarily be performed by persons having medical training and that "TH" has made no representations that treatment will be performed by persons with such training. I also authorize "TH" and its agents or employees to voluntarily and gratuitously arrange transportation for me for the purpose of obtaining medical treatment elsewhere. In return for any such treatment or transportation for treatment elsewhere, I for myself, my heirs, successors and assigns, hereby now and forever RELEASE, ACQUIT, and DISCHARGE "TH" and its agents, employees, officers, directors, parent companies, subsidiaries, successors and assigns of and from any and all claims, demands, actions, remedies, causes of action, liability, damages, costs (including reasonable attorney fees), expenses and losses of every kind or nature, whether at this time known or unknown, anticipated or unanticipated, direct or indirect, which I for myself, my heirs, successors, representatives and assigns now have or may have in the future by reason of my use of the facilities, whether caused by the acts or omissions of "TH" or its employees, agents, or representatives, or by any other person or persons. I further give my consent to "TH" and it agents or employees to make arrangements with third parties for medical treatment or transportation to any emergency medical service, physicians, nurses, other medical personnel or hospitals that "TH" and its agents or employees may select, in their sole discretion, and I agree that I will assume full responsibility for payment for such treatment and/or transportation.

I acknowledge that I have carefully read and fully understand all of the provisions contained in this Consent and Release, and that I have freely and voluntarily chosen to agree to the same. I fully understand that this is a full and complete consent and release of any and all claims and that no additional consideration will be paid to me by and party hereby released.

Client Name _____ **Date_____**

Signature_____

If the person participating is not yet 18 years old: As a parent or legal guardian of the above–named child, I verify that I fully agree to, understand, and accept all provisions of this Waiver, Release, and Consent.

Parent/Guardian Name_____ **Date_____**

Parent/Guardian Signature_____

FASTER
MEDICAL HISTORY FORM

NAME		SPORT	GRADE THIS FALL
DOB	HOME#	HEIGHT	WEIGHT
PARENT/GUARDIAN		CELL#	WORK#
EMERGENCY CONTACT (IF DIFFERENT FROM ABOVE)		PHONE #	

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO	
		HEART CONDITION			ARTHRITIS
		LUNG/BREATHING CONDITION			PREVIOUS SURGERY
		ALLERGIC REACTION TO MEDS			ALLERGIES
		EPILEPSY/SEIZURES			DIABETES
		HIGH BLOOD PRESSURE			BLEEDING (HEMOPHILIA)
		HERNIA/RUPTURE			OTHER

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

DO YOU CURRENTLY YOU CURRENTLY HAVE ANY PHYSICAL RESTRICTIONS, PLEASE EXPLAIN:

HAVE YOU EVER INJURED ANY OF THE FOLLOWING, INCLUDING FRACTURES, DISLOCATION, SPRAINS, STRAINS, CONCUSSIONS, BRUISES? PLEASE INDICATE IF SURGERY WAS NECESSARY.

HEAD/NECK:

NOSE, FACE, TOOTH OR JAW

SHOULDER, ARM OR HAND

BACK, RIBS OR ABDOMEN

HIP, LEG, KNEE, ANKLE OR FOOT

DO YOU WEAR GLASSES/CONTACT LENSES? _____YES NO_____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? _____YES NO_____ IF YES, PLEASE LIST:

*** SIGNATURE INDICATES STUDENT HAS BEEN SEEN BY PHYSICIAN WITHIN 1 YEAR AND IS CLEARED FOR ACTIVITY**

STUDENT SIGNATURE

*PARENT/GUARDIAN SIGNATURE (REQUIRED)