Trinity Sports Medicine offering FASTER Injury prevention program at TRINITY DYRLAND ROOM

Start first week of June, End last week of July

Purpose: Trinity FASTER program is designed to decrease the chance of injuries commonly seen in athletics and increase performance. This program is also specifically designed to address strength performance to athletics and can be tailored to specific sports!

Program Specifics:
Designed and implemented by Certified Athletic Trainers with direction of Sports Medicine Medical Director

Program components:

- Dynamic Warm-up, including ACL prevention program components of Santa Monic Pep ACP Prevention and FIFA 11+
- Hip flexor and Gluteus medius strength and flexibility
- Footwork agility
- Balance training, single leg and bilateral
- Core Strengthening
- Jump training with focus on body positioning for take off and landing mechanics
- Functional movement patterns

Program dates and prices:

- Vary according to program choice
- Price
  - General FASTER $110 Early Bird by May 20th, $125 after
  - Sport Specific FASTER $150 early bird by May 20th, $165 after
- Deadline is May 27th
- All sessions at new Trinity Dryland Room in middle rink area, main level of Maysa Arena

Space is limited per class. Additional Classes may be added if needed.
If questions, call Robyn Gust 857-3486

PROPERTY OF TRINITY FASTER ATHLETICS

Name:_____ School:_____

Email _____

Phone number: _____ Age_____

I am entering grade _____ I am: Male _____ Female _____

Session time date (Circle Session):

General FASTER	Mon/Wed 9:30 am-10:30 am
General FASTER grades 5-8	Mon/Wed 10:30 am-11:30 am
General FASTER	Tues/Thur Noon-1 pm
Figure Skating	Mon/Wed Noon-1 pm
Soccer	Tues/Thurs 9:30 am-10:30 am
Soccer	Tues/Thurs 10:30 am-11:30 am
Jump/Gymnastics	TuesThurs 1:00 pm-2:00 pm

T-Shirt size: SM MED LG XL XXL

I participate in the following sports: _____

Goals I have for the summer are:

_____

Fee: General FASTER $110 if by May 20th, $125 after May 20th

Sport Specific $150 if by May 20th, $165 after May 20th.

Deadline May 27th

Return forms and fees to:

Trinity Sports Medicine, 101 3rd Ave Suite 102, Minot, 58701

Attn: Robyn

Needed to complete application: ___ Application form ___Medical History ___ Waiver ___Check to Trinity

****Questions call Robyn Gust at 857-3486****

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)