

WINNERS EDGE HOCKEY

301 Walnut Street

Spooner WI 54801

Toll free: 1-800-659-5885 Fax: 715-635-6803

Boys Session II - August 3 - August 9

Dear athlete,

I would like to take this opportunity to thank you for choosing Winners Edge Development Camps. Our staff is looking forward to meeting you and helping you to become a better player. This year our program will be filled with high intensity drills, competitive games, and a lot of fun. Listed below are a few items you may want to bring with you. Also listed, are some mandatory items that you need to complete.

Registration will begin at 6:00 pm on Sunday August 3rd. Player orientation will follow at 6:45. At this time we will go over camp rules, procedures, and room assignments, as well as our weekly itinerary. Also we will answer any questions that you may have. Check out time will be at 11:15 to 12:00 on Saturday, August 9th. Attached is a health history form. This form **MUST** be completed and returned as soon as possible. You need to mail this form to: Winners Edge Development, Attn: Scott Turnbull, 301 Walnut Street, Spooner WI 54801

Note: No meal will be served on Sunday night.

See you on the ice!

Scott Turnbull
Director

List to bring:

Toiletries
Dry land clothes, shoes, stick
Extra equipment
Extra money for concessions & recreation
Swimsuit
Sunscreen
Hockey equipment
Clothes for the week
Stick handling ball
Water bottle -SLEEPING BAG!

Extra money for:

Mini Golf
Dairy Queen
Go Karts
Skate Sharpening
Pro Shop

NOTE: We will have a bank system for each player to avoid any money that may be misplaced or otherwise disappears!

Winners Edge Health History Questionnaire -Girls

Participant

Last First MI Soc. Sec. #

Home Address City State Zip

Date of Birth Sex Height Weight

Parent/Guardian _____

Home Phone () _____ - _____ Work Phone () _____ - _____

In case of emergency (injury or illness), if you are unable to be contacted, we should contact:

Name _____ Relationship _____ Phone _____

Name of Physician _____ Phone _____

Insurance Co. _____ Policy # _____

Immunization Record _____ Date _____

*MMR (measles, mumps, rubella)

Dose 1 – Immunization at 12 months _____ Dose 2 _____

*Tetanus Diphtheria

Year of initial series _____ Year of last tetanus booster _____

Have you ever had major surgery or been hospitalized? _____

Please explain any significant operations, accidents or illness and last medical attention and reason:

Does the participant have any physical condition(s) that require special considerations? Explain:

Does the participant have allergic reactions to any of the following?

YES **NO**

Penicillin _____

Other Antibiotics _____

Other Medicines _____

Insect Bites/Stings _____

Other Allergies _____

Taking any regular medications _____

If yes, please identify: _____

Has participant had or presently experiencing any of the following:

| | YES | NO | | YES | NO |
|---------------|-------|-------|-----------------------|-------|-------|
| Allergies | _____ | _____ | High Blood Pressure | _____ | _____ |
| Asthma | _____ | _____ | Joint Injury/surgery | _____ | _____ |
| Bleeding Dis | _____ | _____ | Kidney Disease | _____ | _____ |
| Cancer | _____ | _____ | | | |
| Colitis | _____ | _____ | Neck/Back Pain injury | _____ | _____ |
| Diabetes | _____ | _____ | Mental Problems | _____ | _____ |
| Epilepsy | _____ | _____ | Rheumatic Fever | _____ | _____ |
| Seizures | _____ | _____ | Tuberculosis | _____ | _____ |
| Heart Disease | _____ | _____ | Ulcers | _____ | _____ |
| Hernia | _____ | _____ | | | |
| Other | | | | | |

The health history listed above is correct, as far as I know, and the above participant has my permission to engage in all program activities unless otherwise noted. If a serious illness or injury develops, medical and or hospital care will be given. Staff members are not responsible in case of accidental injury or illness. Further, I understand that in case of medical emergency I will be notified. In the event that I cannot be reached, I hereby give my permission to the attending physician to hospitalize, ensure proper treatment for, and to order injection, anesthesia or surgery for the participant as named above.

Signature of Parent or Guardian Date