WINNERS EDGE HOCKEY
301 Walnut Street
Spooner WI 54801
Toll free: 1-800-659-5885 Fax: 715-635-6803

GIRLS CAMPER PACKET -July 2008

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 July 13th. 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 July 19th. 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 mis-placed 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	_____	_____	Menstrual Disorder	_____	_____
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.

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Signature of Parent or Guardian   Date