



JUNIOR GAELS YOUTH WRESTLING PROGRAM

**Open to Boys & Girls
Grades 1-8
6:00 PM to 7:30 PM
Mondays, Wednesdays & Thursdays**

**Bishop Gorman Wrestling Room
5959 S. Hualapai Way
Las Vegas, NV 89148**

Cost is \$75 per month.

Wrestling Helps a Young Athlete Develop:

- **Agility** – The ability to change the position of the body efficiently.
- **Quickness** – The ability to make a series of movements in a very short period of time.
- **Balance** – The maintenance of body equilibrium through muscular control.
- **Flexibility** – The ability to make a wide range of muscular movements.
- **Coordination** – The ability to put together a combination of movements in a flowing rhythm.
- **Endurance** – The development of muscular and cardiovascular-respiratory stamina.
- **Muscular Power (explosiveness)** – The ability to use strength and speed simultaneously.
- **Aggressiveness** – The willingness to keep on trying or pushing you adversary at all times.
- **Discipline** – The desire to make the sacrifices necessary to become a better athlete and person.
- **Winning Attitude** – The inner knowledge that you will do your best – win or lose.

Please visit the Bishop Gorman Website at
www.bishopgorman.org to download
Registration Form and Diocesan Liability Waiver

For more information, please email
Head Coach Ricky Lundell at rickylundell@gmail.com



JUNIOR GAELS YOUTH WRESTLING PROGRAM

Important Information:

Bishop Gorman will be hosting a wrestling youth program for boys and girls in grades 1 through 8. Each participant should wear gym shorts and t-shirt suitable for working out. Participants should be ready for intense training focusing on competition preparation for all levels of wrestling. Bishop Gorman coaches and varsity wrestlers will be teaching skills and coaching the participants.

Camp Dates: **Mondays / Wednesdays / Thursdays**
November 1, 2016 through May 31, 2017
6:00 PM – 7:30 PM

Payment:

The cost of the camp is \$75 per month. Please download and complete the Diocesan Liability Waiver form, attach the completed registration sheet and send with payment to:

BISHOP GORMAN HIGH SCHOOL
ATTN: ATHLETICS
5959 SOUTH HUALAPAI WAY
LAS VEGAS, NV 89148

CHILD'S NAME: _____ AGE: _____
CURRENT GRADE: _____ SCHOOL: _____
PARENT'S/GUARDIAN'S NAME: _____
MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME #: _____ CELL #: _____
EMAIL ADDRESS: _____

I, the undersigned parent or legal guardian, gives permission for _____ to participate in the Junior Gaels Youth Wrestling Program from November 1, 2016 – May 31, 2017. I assume all responsibility for any injuries that may occur to the above mentioned minor. I agree to release BGHS, the coaches, or any wrestling instructors from all claims. If you have any questions, please contact Head Coach Ricky Lundell at rickylundell@gmail.com.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____
EMERGENCY PHONE # DURING CAMP HOURS: _____
EMERGENCY CONTACT: _____ PHONE #: _____

PREPARTICIPATION HISTORY FORM

**EXPLAIN "YES" ANSWERS BELOW.
CIRCLE QUESTIONS YOU DON'T KNOW THE ANSWER TO.**

	<u>Yes</u>	<u>No</u>
1. Do you have a chronic medical condition (asthma, diabetes high blood pressure, etc.)?	_____	_____
2. Have you ever been hospitalized overnight?	_____	_____
3. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills or using an inhaler?	_____	_____
4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insect)?	_____	_____
5. a. Have you ever passed out or been dizzy during exercise?	_____	_____
b. Have you had chest pain (or pressure) with exercise?	_____	_____
c. Have you had excessive unexplained shortness of breath or fatigue with exercise?	_____	_____
d. Is there a family history of premature death or morbidity from cardiovascular disease in a relative younger than age 50?	_____	_____
e. Is there any history in your family of hypertropic cardiomyopathy, dilated cardiomyopathy long QT syndrome or Marfan's syndrome?	_____	_____
f. Has a physician denied or restricted your participation in sports for any heart problem?	_____	_____
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?	_____	_____
7. a. Have you ever had a head injury or concussion?	_____	_____
b. Have you been knocked out, become unconscious, or lost your memory?	_____	_____
c. Have you had a seizure?	_____	_____
d. Do you have frequent or severe headaches?	_____	_____
e. Have you had numbness or tingling in your arms, hands, legs, or feet?	_____	_____
8. Have you become ill from exercising in the heat?	_____	_____
9. Do you cough, wheeze, or have trouble breathing during or after activity?	_____	_____
10. a. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	_____	_____
b. Are you missing an eye, kidney, testicle, or ovary?	_____	_____
11. a. Have you had any problems with your eyes or vision?	_____	_____
b. Do you wear glasses, contacts, or protective eyewear?	_____	_____
12. a. Have you had any problems with pain or swelling in muscles, tendons, bones, or joints?	_____	_____
b. If yes, check appropriate item and explain below:		
___ Head ___ Elbow ___ Hip ___ Neck ___ Forearm ___ Thigh		
___ Back ___ Wrist ___ Knee ___ Chest ___ Hand ___ Shin/Calf		
___ Shoulder ___ Finger(s) ___ Ankle ___ Upper Arm ___ Foot ___ Toe(s)		
13. Are you actively trying to gain or lose weight?	_____	_____
14. Would you like to talk to someone about stress, anger, depression, or other issues?	_____	_____
15. Record the dates of your most recent immunizations (shots) for: Tetanus _____ Measles _____ Hepatitis B _____ Chickenpox _____		

FEMALES ONLY

16. When was your first menstrual period? _____
 When was your most recent menstrual period? _____
 How much time do you usually have from the start of one period to the start of another? _____
 How many periods have you had in the last year? _____
 What was the longest time between periods in the last year? _____

EXPLAIN "YES" ANSWERS HERE: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

 Signature of Parent/Guardian

 Signature of Student

 Date

PRE-PARTICIPATION PHYSICAL EVALUATION FORM

PHYSICAL EXAMINATION		DATE OF EXAMINATION: _____
NAME: _____	DATE OF BIRTH: _____	
HEIGHT: _____	WEIGHT: _____	% BODY FAT (OPTIONAL): _____ PULSE: _____ BP: _____/_____/_____ (_____/_____, _____/_____) _____
VISION: R 20/ _____	L 20/ _____	CORRECTED: Y / N PUPILS: Equal _____ Unequal _____

<u>MEDICAL</u>	NORMAL/ ABSENT	ABNORMAL FINDINGS	EXPLAIN	INITIALS
Appearance				
Eyes/Ears/Nose/Throat				
Lymph Nodes				
Lungs				
Abdomen				
Genitalia (Males Only)				
Skin				
<u>CARDIOVASCULAR</u>				
Murmur that Increases From Supine to Standing				
Systolic Murmur Greater Than II/VI				
Any Diastolic Murmur				
Radial & Femoral Pulses				
<u>MUSCULOSKELETAL</u>				
Neck				
Back				
Shoulder/Arm				
Elbow/Forearm				
Wrist/Hand				
Hip/Thigh				
Knee				
Leg/Ankle				
Foot				
Stigmata of Marfan's Syndrome				

CLEARANCE

CLEARED: _____

Cleared after completing evaluation/rehabilitation for: _____

NOT CLEARED FOR: _____ **Reason:** _____

Recommendations: _____

NAME OF PHYSICIAN (*print/type*): _____ Phone: _____

Address: _____

I, _____ Street _____ City _____ State _____ Zip _____ hereby certify that I am a licensed _____, qualified to perform NIAA Pre-Participation evaluation, and that on the date set forth below I performed all aspects of the NIAA Pre-Participation Evaluation on the above student. The student meets all physical examination requirements for participation in NIAA sanctioned sports.

Signature of Health Practitioner _____ License Number _____ Office Phone Number _____ Date _____

Revised 3-2010

Diocese of Las Vegas
FIELD TRIP
Bishop Gorman High School
Parent/Guardian Consent Form and Liability Waiver

Participant's name: _____

Birth date: _____ Sex: _____

Parent/Guardian name: _____

Home address: _____

Home phone: _____ Cell phone: _____

E-mail address: _____

I/We, _____, grant permission for my child,

Parent/Guardian name

_____ to participate in this Bishop Gorman High School activity

Child's Name

that requires transportation to a location away from the Bishop Gorman High School campus. This activity will take place under the guidance and direction of Bishop Gorman High School employees and/or volunteers.

A brief description of the activity follows:

Type of event: JUNIOR GAELS YOUTH WRESTLING PROGRAM

Date of event: MONDAYS, WEDNESDAYS & THURSDAYS NOVEMBER 1, 2016 - MAY 31, 2017

Destination of event: BGHS GYM/WRESTLING ROOM

Individual in charge: HEAD COACH RICKY LUNDELL

Estimated time of departure and return: 6:00 PM – 7:30 PM

Mode of transportation to and from event: SELF/PARENT

As a parent and/or legal guardian, I/we remain legally and financially responsible for any personal actions taken by the above named minor ("participant").

When it is necessary to arrange for overnight accommodations for a field trip the following Diocesan policy will be effective:

- Students may room with their parent chaperone(s).
- Chaperones and teachers must be roomed with chaperones and teachers only.
- It is not permissible for a student to be roomed with a chaperone or teacher; students must be roomed with other students only.

I/We agree on behalf of my myself, my child named herein, or our heirs, successors, and assigns, to release and waive any and all claims for damages which I/we or our child may have so as to release and discharge in advance those parties hereinafter named and further agree to indemnify, hold harmless and defend the Roman Catholic Bishop of Las Vegas, and His Successors, a Corporation Sole (The Diocese of Las Vegas), its officers, directors and agents, volunteers, chaperones, and/or representatives, and Bishop Gorman High School from any and all liability arising from or in connection with my child attending the event or in connection with any illness or injury or cost of medical treatment in connection herewith, and I/we further agree to compensate Bishop Gorman High School and the Diocese, its officers, directors, agents, volunteers, chaperones, and/or representatives associated with the event for reasonable attorney fees and expenses arising in connection therewith.

Signature: _____ Date: _____

Print name: _____

Medical Matters: I/We hereby warrant that to the best of my/our knowledge, my/our child is in good health, and I/we assume all responsibility for the health of my/our child. (OF THE FOLLOWING STATEMENTS PERTAINING TO MEDICAL MATTERS, SIGN ONLY THOSE THAT ARE APPLICABLE.)

Emergency Medical Treatment: In the event of an emergency, I/we hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I/We wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me/us at the above numbers, contact:

Name & relationship: _____ Phone: _____

Name & relationship: _____ Phone: _____

Family doctor: _____ Phone: _____

Family health plan carrier: _____ Policy #: _____

Signature: _____ Date: _____

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise direction for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows:

Signature: _____ Date: _____

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life threatening and emergency treatment is required.

Signature: _____ Date: _____

I/We hereby grant permission for non-prescription medication (such as acetaminophen, throat lozenges, cough syrup) to be given to my child, if deemed appropriate.

Signature: _____ Date: _____

Specific Medical Information: The Parish/School/Institution will take reasonable care to see that the following information will be held in confidence.

Allergic reactions (medications, foods, plants, insects, etc.): _____

Immunizations: Date of last tetanus/diphtheria immunization: _____

Does child have a medically prescribed diet? _____

Are there any physical limitations? _____

Is your child subject to any chronic conditions? _____

You should be aware of these special medical conditions of my child: _____

THIS RELEASE MUST BE SIGNED BY BOTH PARENTS/GUARDIANS. If only one parent signs this document, that parent presents and warrants to the Diocese that he/she is the sole custodial parent of the student participant with the authority to sign this waiver and release form.

Signature of Father/Guardian: _____ Date: _____

Signature of Mother/Guardian: _____ Date: _____

Parent(s)/Guardian's phone number in case of emergency: _____ or _____