WINGS SOCCER CAMP

JULY 19th-23rd

8:00 a.m.-12:00 p.m.

FOR GRADES 6-12

Price: $300

A SOCCER CAMP FOR GIRLS

CAMP LOCATION

Academy of the Holy Angels

315 Hillside Avenue
Demarest, NJ

Head Coach

Bill Potkulski

bpotkulski@holyangels.org

An East Brunswick, NJ native, Bill Potkulski was a college athlete at Penn State University. With a BA in Physical Education, he has been teaching elementary PE for twelve years in Closter, NJ. He possesses a Masters degree in Athletic Administration and Coaching, and is the varsity soccer and lacrosse coach at AHA where he has been coaching for the past eleven years. He is also co-owner of the business Learn2Lax.

Required Equipment:
****Soccer Cleats***
****Shin Guards***
****Soccer Socks***

Coach Megan Delasandro
&
Former AHA Players
may be on staff for camp

Assistant Coach

Sean Liddy

sliddy1@holyangels.org

A River Vale, NJ native, Sean Liddy is a scholar-athlete that graduated from Pascack Valley HS before attending SUNY Cortland where he graduated with a BS in Sports Management. He possesses his Masters degree in physical education and is currently in his third year of teaching PE. Sean has been a HS soccer coach for six years, including serving as head girls soccer coach at Cresskill HS. Sean coaches baseball at Cresskill HS and basketball at AHA.

For information on other camps:
www.holyangels.org/athletics

WINGS SOCCER CAMP REGISTRATION FORM

JULY 19th - 23rd (8:00 a.m. - 12:00 p.m.)

Fee: $300 *Made Payable to "Wings Sports Camps"*

**Non-Refundable*

Mail Registration and Health Forms to:

Academy of the Holy Angels
Attn: Athletic Department
Wings Soccer Camp
315 Hillside Avenue
Demarest, NJ 07627

PARTICIPANT INFORMATION

FIRST NAME_____ LAST NAME _____

AGE _____ GRADE (as of Sept. '21) _____ SOCCER EXPERIENCE (yrs.)_____

CURRENT SCHOOL _____ ANTICIPATED HS _____

PARENT/GUARDIAN INFORMATION

FIRST NAME_____ LAST NAME _____

EMAIL _____ CELL PHONE_____

STREET ADDRESS _____ TOWN_____

EMERGENCY CONTACT _____ CELL PHONE_____

COVID-19 PROTOCOL

ALL PARTICIPANTS MUST:

- Receive a PCR Covid Test between July 10th and July 12th.
- Email results to MBuckey@holyangels.org by July 15th at the latest.
- Bring a mask which will be worn when appropriate.
- Bring a personal water bottle.
- Submit an online DAILY HEALTH CHECK before arrival each day.
  (A link will be provided via email prior to the start of camp)

PARENT/GUARDIAN CONSENT

As a parent/legal guardian of_____, I hereby give my full consent and approval for my child to participate in the Wings Soccer Camp at the Academy of the Holy Angels. I understand that good physical condition and freedom from injury are prerequisites to participate in this athletic activity. I certify that I have no knowledge of any physical impairment that would affect my child's participation in this camp program. In addition to giving my full consent for my child's participation, I do hereby waive release, and hold harmless any camp facility, coach, and supervisor by my child in the normal course of participation and activities incidental thereto, whether a result of negligence or any other carelessness.

PARENT SIGNATURE_____ **DATE** _____

Date of last Physical _____ Date of last Tetanus _____

STUDENT NAME _____
(LAST) (FIRST) (MI)

_____
(STREET ADDRESS) (CITY) (STATE) (ZIP) (PHONE)

DATE OF BIRTH ____/____/____ AGE ____ GRADE 9 10 11 12 (CIRCLE ONE) Sport _____

Mother's Name _____ **Father's Name** _____

Medical History

MUST BE COMPLETED BY PARENT ANSWER ALL QUESTIONS INCOMPLETE FORMS WILL BE RETURNED

HAS STUDENT EVER EXPERIENCED :	NO	YES	Dates ALL YES ANSWERS MUST BE EXPLAINED
ALLERGIES			
Asthma /Reactive Airway/ Any Breathing Problems			
Blood Disorders/Nose Bleeds			
Cancer			
Chicken Pox			
Diabetes			
Headaches/ Concussion/ Unconsciousness/Memory Loss/ Head Blow/Black Outs			
Hearing Problems/Hearing Aid			
Heart Disease/Problems with exercise			
Hepatitis			
Hi/Lo Blood Pressure/Fainting			
Hospitalizations/Infections/ER Visits			
Kidney /Urinary Tract Problem			
Medication Reactions			
Menstrual Disorder			
Mononucleosis/Fatigue/Tiredness			
Muscular Disorder/Ligament/ Tendon Damage/Injury/Sprains			
Orthopedic Disorder/ Broken Bones			
Chest Pain/Racing Heart			
Scoliosis			
Seizure Disorder			
Strep Infections			
Surgery/Outpatient Procedures/Tests			
Ulcer/Gastrointestinal Disorder			
Visual Problems/Glasses/Contact Lenses			
Other			

Since the last physical has there been any incident of Heart Attack/Heart Trouble in a family member under 50 years Of age? ___N ___Y Any Incident of Sudden Death of a Family Member ? ___ N ___ Y

Does student take any medication on a regular basis? ____N ___ Y Name of Medication _____

Recently stopped a medication? ____N ____Y Name of Medication _____

Has the student ever been advised by a physician not to play a sport? ____ N ____Y Reason _____

PARENT SIGNATURE STUDENT SIGNATURE DATE

STUDENT CONTACT INFORMATION

Student Name _____ Grade in September _____

Address _____ Town _____

Home # _____ Student Cell # _____ Student E Mail _____

Father's Name _____ Home # _____

Place of Business _____ Work # _____

E MAIL _____ Cell # _____

Mother's Name _____ Home # _____

Place of Business _____ Work # _____

E MAIL _____ Cell # _____

EMERGENCY CONTACTS

1. _____ Tel # _____

Relationship _____

2. _____ Tel # _____

Relationship _____

EMERGENCY MEDICAL INFORMATION

Allergies : NO _____ YES _____ TYPE: _____

EMERGENCY MEDICATION : NO _____ YES _____ TYPE : _____

Daily medication : NO _____ YES _____

Asthma : NO _____ YES _____ MEDS : _____

Other : _____

Insurance Co. _____ Policy # _____

THIS INFORMATION WILL BE SHARED WITH ALL APPROPRIATE SCHOOL PERSONNEL AS NEEDED.

Parent Signature _____ Student Signature _____

Date _____

New Jersey Department of Education
Health History Update Questionnaire

Name of School: _____

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.

Student: _____ Age: _____ Grade: _____

Date of Last Physical Examination: _____ Sport: _____

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport? Yes ☐ No ☐
   If yes, describe in detail:
2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes ☐ No ☐
   If yes, explain in detail:
3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes ☐ No ☐
   If yes, describe in detail.
4. Fainted or "blacked out?" Yes ☐ No ☐
   If yes, was this during or immediately after exercise?
5. Experienced chest pains, shortness of breath or "racing heart?" Yes ☐ No ☐
   If yes, explain
6. Has there been a recent history of fatigue and unusual tiredness? Yes ☐ No ☐
7. Been hospitalized or had to go to the emergency room? Yes ☐ No ☐
   If yes, explain in detail
8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes ☐ No ☐
9. Started or stopped taking any over-the-counter or prescribed medications? Yes ☐ No ☐
10. Been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

    If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic? Yes ☐ No ☐

    If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized? Yes ☐ No ☐
11. Has any member of the student-athlete's household been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

Date: _____ Signature of parent/guardian: _____

Please Return Completed Form to the School Nurse's Office