



# 2018 Dynasty Winter Camp

December 8-9<sup>th</sup>, 2018

The Park at Briar Chapel - Pittsboro, NC

## DETAILS

- ◆ The camp will be run by Dynasty Goalkeeping owner TRACY NOONAN. [www.dynastygoalkeeping.com](http://www.dynastygoalkeeping.com)
- ◆ Open to MALE & FEMALE goalkeepers ages 12-18.
- ◆ **SMALL GROUPS = PLENTY OF REPS!** The camp will be limited to a maximum of 15 students.
- ◆ 2-3 staff coaches depending on enrollment to ensure a 5:1 player to coach ratio.
- ◆ Each student will receive a Dynasty Goalkeeping T-Shirt (or Dynasty calf socks based on availability).
- ◆ Cost is \$425 (4 sessions and 2 lectures).
- ◆ Lunch is NOT provided.

**FIELD LOCATION** – The Park at Briar Chapel – 1015 Andrews Store Road, Pittsboro, NC 27312

<http://www.chathamnc.org/government/departments-programs/parks-recreation/county-parks-trails/the-park-at-briar-chapel>

## SCHEDULE (tentative)

### Saturday, December 8<sup>th</sup>

9a – 11a	Session 1	TOPIC: Handling & Technical Breakaways
11:30 – 12p	LUNCH	<i>*Students bring their own lunch &amp; we will eat at onsite classroom</i>
12 – 1p	Lecture	TOPIC: Positioning & Communication
1:30 – 4p	Session 2	TOPIC: Functional Breakaways & Small Sided Games

### Sunday, December 9<sup>th</sup>

9a – 11a	Session 3	TOPIC: Diving & High Balls/Crosses
11:30 - 12p	LUNCH	<i>*Students bring their own lunch &amp; we will eat at onsite classroom</i>
12 – 1p	Lecture	TOPIC: Nutrition
1:30 – 4p	Session 4	TOPIC: 3 Goal Situation, Kicking & Small Sided Games

## CAMP CANCELLATION

A minimum of 10 students will be required to host the camp. Payments will not be processed until we have our minimum number and if the camp is cancelled due to low enrollment all money will be refunded.

## INCLEMENT WEATHER POLICY

We will train in rain/snow/cold, so dress appropriately. In the event of severe weather that would impact the entire weekend, every effort will be made to reschedule for January 5 – 6<sup>th</sup>, 2019. No refunds will be given if a student cannot attend on the inclement weather back-up date, so please plan accordingly. If we are unable to reschedule, credit for a future Dynasty camp will be offered or a refund will be given.





# Medical Release Form

NAME \_\_\_\_\_ SEX \_\_\_\_\_ AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ YEAR OF GRADUATION \_\_\_\_\_

PERSONAL PHYSICIAN & PHONE \_\_\_\_\_

IN CASE OF EMERGENCY CONTACT: NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

PHONE (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

**EXPLAIN "YES" ANSWERS BELOW AND CIRCLE QUESTIONS YOU DO NOT KNOW THE ANSWERS TO.**

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Have you had a medical illness or injury since your last checkup or sports physical?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Have you ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?  | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Have you ever taken any supplements or vitamins to help you gain or lose weight to improve your performance?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Have you ever been dizzy during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you ever had chest pain during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do you get tired more quickly than your friends do during exercise?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you ever had racing of your heart or skipped heartbeats?  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have you had high blood pressure or high cholesterol?  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Have you ever been told you have a heart murmur?   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Has any family member or relative died of heart problems or of sudden death syndrome before age 50?  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Has a physician ever denied or restricted your participation in sports for any heart problems?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus or blisters)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Have you ever been knocked out, become unconscious or lost your memory?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do you have frequent or severe headaches?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you ever had numbness or tingling in your arms, hands, legs, or feet?   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Have you ever had a stinger, burner, or pinched nerve?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever become ill from exercising in the heat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you cough, wheeze or have trouble breathing during or after activity?   | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Do you have asthma?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you have seasonal allergies that require medical treatment?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you use any special protective or corrective equipment or devices that aren't normally used for your sport or position (for example, knee braces, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had any problems with your eyes or vision?   | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Do you wear glasses, contacts, or protective eyewear?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had a sprain, strain, or swelling after injury?   | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?  | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, check appropriate box and explain below:

- |           |                          |         |                          |           |                          |
|-----------|--------------------------|---------|--------------------------|-----------|--------------------------|
| Head      | <input type="checkbox"/> | Elbow   | <input type="checkbox"/> | Hip       | <input type="checkbox"/> |
| Neck      | <input type="checkbox"/> | Forearm | <input type="checkbox"/> | Thigh     | <input type="checkbox"/> |
| Back      | <input type="checkbox"/> | Wrist   | <input type="checkbox"/> | Knee      | <input type="checkbox"/> |
| Chest     | <input type="checkbox"/> | Hand    | <input type="checkbox"/> | Shin/calf | <input type="checkbox"/> |
| Shoulder  | <input type="checkbox"/> | Finger  | <input type="checkbox"/> | Ankle     | <input type="checkbox"/> |
| Upper Arm | <input type="checkbox"/> | Foot    | <input type="checkbox"/> |           |                          |

13. Record the dates of your most recent immunization shots for:

Tetanus \_\_\_\_\_ Measles \_\_\_\_\_

Hepatitis B \_\_\_\_\_ Chicken Pox \_\_\_\_\_

14. **CURRENT** Health Insurance information:

Company: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

**PLEASE ENCLOSE A COPY OF THE FRONT & BACK OF YOUR CURRENT MEDICAL CARD.** This is necessary for treatment at the Urgent Care Center. Also, should you change providers between now and the start of camp please mail us the updated information. Thank you!

EXPLAIN "YES" ANSWERS HERE (or back if more space is needed):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CONSENT TO TREAT:**

*All students must have their own medical coverage. Dynasty Goalkeeping LLC provides only excess coverage after your insurance policy has been utilized. Students will not be allowed to play unless the following is signed by the parent or guardian of the student. I, the undersigned, hereby certify that I am the parent or legal guardian of the student. I hereby give permission for the staff of Dynasty Goalkeeping LLC to seek, during the period of the camp, appropriate medical attention for the student in the event of accident, injury, or illness. I will be responsible for any and all costs of medical attention and treatment, except for that covered by Dynasty Goalkeeping LLC's excess medical coverage policy.*

*I attest that my child has had a physical examination in the past 12 months and has been cleared to participate in athletic activities without any restrictions. This physical is on file at their high school or at our home.*

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

SIGNATURE OF ATHLETE

\_\_\_\_\_  
Date: \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
Date: \_\_\_\_\_