

Dynasty Goalkeeping Application

Please review the program descriptions below to help you choose which level is appropriate. Acceptance into a program will be based on a review of the student's application to assure proper placement of all goalkeepers. It is important that goalkeepers are appropriately placed so that all students will be challenged and get the most out of their week at Dynasty.

Level 1 - "SELECT" - This level is designed for goalkeepers who want to solidify and sharpen their technique. It is ideal for younger students, those who have not attended a goalkeeper specific camp before, or for repeat students who need to focus on their technique and developing the physical aspects of their game. It is NOT a beginner camp. It will prioritize technical and physical development more than other camp levels.
(Week 7)

Level 2 - "ELITE" - This will remain the traditional camp week and core of Dynasty Goalkeeping. This camp is tailored for the more experienced, competitive goalkeepers -- repeat students (per Tracy's approval), goalkeepers who have attended other goalkeeper specific camps (preferably Soccer Plus Goalkeeper School NTC level or higher), top club and ODP players (Regional Team level or higher preferred).
(Weeks 1, 3, 4*, 5) *NOTE - Week 4 will be reserved for current college players who do not get invited or whom cannot attend a PRO Week and for high school graduates ONLY.

Students **MUST** have at least 2 of the following to be considered for this level of camp (Check all that apply):

Start on a Premier level club team – (List club team, coach's name and contact information)

Have attended another goalkeeper specific camp (List camps attended and years)

Have attended Dynasty Goalkeeping Academy previously (List date attended)

Youth National Team or Regional Team ODP player (List teams and years)

Level 3 - "PRO" - This week is by **INVITATION ONLY**. It will be aimed at serious college players who want to maximize their potential in college and perhaps play beyond college on the national team or professionally. More emphasis is placed on the tactics of the position and getting functional quicker to get more repetitions in game like scenarios to improve decision making. The group is more selective as I feel it is critical to get the right group of goalkeepers to maximize what this week has to offer. Repeat students will get priority and it will be aimed at current college players, top college bound goalkeepers, and youth National Team players who can compete at this level. (Weeks 2 & 6)



Medical Release Form

NAME _____ SEX F 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 Academy 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 Academy to seek, during the period of the Academy, 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 Academy'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: _____