



# WINGS LACROSSE CAMP

**JULY 18th-22nd**

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

FOR GRADES 4-12

Price: \$300

A LACROSSE CAMP FOR GIRLS



Head Coach

**Bill Potkulski**

[bpotkulski@holyangels.org](mailto: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.

**CAMP LOCATION**  
*Academy of the  
Holy Angels*

**315 Hillside Avenue  
Demarest, NJ**

**Required Equipment:**

- \*Girls Stick**
- \*Goggles**
- \*Mouth Guard**
- \*Cleats or Sneakers**

**Other Coaches  
&  
Former AHA Players  
will be on staff for camp**



Assistant Coach

**Taryn Tabano**

[ttabano@holyangels.org](mailto:ttabano@holyangels.org)

Taryn Tabano was the head coach of Girls Varsity Lacrosse at Glen Rock for nine years where she helped lead her team to over 100 wins. Taryn is now an assistant at AHA and works in higher education. She is also the director of girls lacrosse for the Bergen County Women's Coaches Association, running the county tournament and coaching committee for the last six years.



For information on other camps:  
[www.holyangels.org/athletics](http://www.holyangels.org/athletics)

**WINGS LACROSSE CAMP  
REGISTRATION FORM**

**JULY 18th - 22nd (8:00 a.m. - 12:00 p.m.)**

**Fee: \$300** Made Payable to "Learn2Lax"

*\*Non-Refundable*

**Mail Registration and Health  
Forms to:**

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

**PARTICIPANT INFORMATION**

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_

AGE \_\_\_\_\_ GRADE (as of Sept. '22) \_\_\_\_\_ LACROSSE EXPERIENCE (yrs.) \_\_\_\_\_

CURRENT SCHOOL \_\_\_\_\_ ANTICIPATED HS \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_

EMAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ TOWN \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ CELL PHONE \_\_\_\_\_

**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 Lacrosse 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**