Summer 2026

CHAMP

Sports Acceleration

By
CMC Physical Therapy

What: Increase your Speed, Agility, Power and Jumping Ability Through 10+ Weeks of Workouts Designed to Develop Athletic Performance

How: Weightlifting, Speed Drills, Plyometrics, Agility Training, and Medicine Balls

Start Date: June 1st (Monday)
**Initial Testing Will Be Performed This Day So Try Not to Miss It!

End Date: August 12th (Wednesday)
**Final Testing Day to See your Improvements!

When: Weeks #1-10 (June 1st – Aug. 6th): Mon, Tues, Wed, Thurs
Week #11 (Aug. 10th – August 12th): Mon, Tues, Wed

Where: Colstrip High School Gym, Football Practice Field, Wrestling Room, Mezzanine

Times: 10:00 AM-11:30 AM

Who: Students Entering Grades 6th-12th

Cost: $100.00 per Participant (Includes a T-Shirt and a Sports Physical for the Upcoming School Year)
$175.00 for Two Participants in the Same Family Household
$250.00 for Three Participants in the Same Family Household

Please Return the Following Forms to the Colstrip Medical Center
Call 748-3600 Ext. 130 or 132 for More Information

Conducted By:
Jonny Dilworth, DPT (Doctor of Physical Therapy/FBMS Head Football Coach)
Becky Suhr, CSCS (Certified Strength and Conditioning Specialist)
Ryan Pedraza (Health & Wellness Director/FBMS Assistant Football Coach)

WEIGHTROOM LIABILITY DISCLAIMER

I hereby give my approval to participate in the CHAMP program.
I assume all risks incidental to the conduct of the class.
I do further release, absolve, indemnify, and hold harmless the instructors (Jonny Dilworth, Becky Suhr, Ryan Pedraza), the Colstrip Medical Center, and Colstrip High School. In case of injury to myself, I hereby waive all claims against the organizers and /or instructors.

_____ _____
DATE SIGNATURE OF PARTICIPANT OR GUARDIAN (IF UNDER 18)

PHYSICIAN CLEARANCE WAIVER

I understand the importance of the medical clearance needed for my present physical status. However, I wish to participate in the CHAMP program at my own risk and agree to indemnify and hold harmless from liability the instructors (Jonny Dilworth, Becky Suhr, Ryan Pedraza), the Colstrip Medical Center, and Colstrip High School, from injury to my body or property incurred while using the weight room facility.

_____ _____
DATE SIGNATURE OF PARTICIPANT OR GUARDIAN (IF UNDER 18)

PHOTO RELEASE FORM

I, _____, a participant of the CHAMP Sports Acceleration Program, authorize Jonny Dilworth, Becky Suhr, Ryan Pedraza, or other designated person(s) to take photographs of me while participating in the program. These photos will **ONLY** be used to promote the program and to advertise upcoming CHAMP programs. They will mainly be used on the Colstrip Public Schools & Colstrip PTO Facebook pages, but may also be used on other forms of advertisement (flyers, brochures, etc.).

CHAMP Participant Signature:_____ Date:_____

Parent/Guardian Signature (if under 18):_____ Date:_____

PARTICIPANT INFORMED CONSENT

We believe that you, as a participant in the CHAMP program, should be aware of the activities included in this class and the discomforts and risks that you might encounter by your participation.

The CHAMP program will be instructed by a First Aid/CPR certified instructor. A progressive workout in each class will include a warm-up and cool down period with aerobic (building upon arm and leg movements) and flexibility exercises. Proper training in exercise technique for strength and flexibility exercises will be incorporated into each class.

The expected benefits of the CHAMP program will include: an increased sense of well-being, increased muscular strength and endurance, increased flexibility, improved muscle tone, improved coordination, improved endurance, and a decreased effect of stress.

The acute risk of participation in a vigorous exercise program such as the CHAMP program is cardiac failure. Even though the chance of failure is unlikely, the possibility does exist. It is because of this risk that we require that each participant adhere to MEDICAL GUIDELINES. Additional discomforts and risks include: soreness, cramping, pulled or torn muscles, joint sprains and strains, stress fractures of the foot or lower leg, shin splints, cartilage or ligament damage to the knees, back muscle sprain or fatigue, nausea during and after exercise, elevated heart rate during and after exercise, heavy breathing during and after exercise, and/or exhaustion and fatigue. We ask that if you suffer from any of these discomforts that you inform our instructors or staff immediately.

Your participation in this program is voluntary and you may withdraw at any time. Your written consent indicates you have full knowledge and understanding of the nature of the CHAMP program, the benefits you may expect, and the discomforts and/or risks which may be encountered and you agree to participate on that basis. Your written consent does further release, absolve, indemnify and hold harmless the facility, instructors, and Colstrip High School, from injury to your body or property incurred while on their property.

CONSENT

_____ _____

DATE SIGNATURE OF PARTICIPANT

_____

SIGNATURE OF PARENT/GUARDIAN IF UNDER 18 YEARS OF AGE

Health Assessment Questionnaire**

I. General Information

Date:_____

Name:_____ Gender: F M Age:_____
Last First M.I.

Parent or Guardian Name(s):_____ Telephone #_____

Birth Date:____/____/____ Height:____ft.____in. Weight:_____pounds

Personal Physician:_____

Sports (circle all that apply):

*Basketball	*Football	*Cross Country
*Volleyball	*Wrestling	*Swimming
*Cheerleading	*Soccer	*Baseball
*Track and Field	*Cornhole	*Golf

*Others:_____

Shirt Order: (please circle Size): Adult

Size: XS S M L XL XXL XXXL

II. Medical Background

Have you or do you have any of the following signs or symptoms? (please check)

	Yes	No		Yes	No
High Blood Pressure	[]	[]	Arthritis	[]	[]
Low Blood Pressure	[]	[]	Painful joints	[]	[]
Lung Disease	[]	[]	Allergies	[]	[]
Diabetes	[]	[]	Asthma	[]	[]
Chest Pain	[]	[]	Muscle problems	[]	[]
Recent Operations	[]	[]	Skeletal problems	[]	[]
Injury to back or knees	[]	[]	Shortness of breath	[]	[]
Seizures	[]	[]	Anorexia Nervosa	[]	[]
Fainting	[]	[]	Concussion	[]	[]
Dizziness	[]	[]	Heat Stroke	[]	[]
Epilepsy	[]	[]	Other	[]	[]

Please explain all answers marked "Yes":_____

_____

_____

_____

If you take any medications for these symptoms, please list names and dosages.

_____

_____

III. Goals

What do you hope to get out of the CHAMP program? _____

_____

_____

_____

**All information will be kept private and confidential.