

Insurance Waiver for Sports Participation

Student's Name _____

School Name _____

Insurance Waiver

The undersigned parent or natural guardian of _____, a minor, hereby warrants to O'fallon School District 90 that the undersigned has secured and will maintain medical and accident insurance covering all physical damages and medical expenses which may be incurred as the result of injury to said minor by reason of his or her practice for and participation in interscholastic athletics, cheerleading, and/or poms during the 20____ - ____ school terms.

This statement is made for the expressed purpose of inducing O'fallon School District 90 to consider said minor eligible for participation in said sports, without the necessity of payment of the usual fee for coverage under the student accident insurance program, which normally is in force to cover said injuries and damage. Further, the undersigned hereby acknowledges that said program has been explained to and understood by him or her and specifically represents that the undersigned does not desire said insurance coverage, and waives any right to make claim under such insurance program.

Dated this ____ day of _____, 20 ____.

Signature of Parent or guardian

O'Fallon C.C. School District 90 Concussion Agreement to Participate

A concussion is a brain injury. It is caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. A concussion can range from mild to severe and disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** Even a "ding" or a bump on the head can be serious. You can't see a concussion and most concussions occur without loss of consciousness. Signs and symptoms of a concussion may appear right after the injury or take hours or days to fully appear. If your child reports any symptoms of a concussion, or if you notice the symptoms or signs of a concussion, seek medical attention right away.

Symptoms Reported by Student-Athlete	Signs observed by others:
Headache	Loss of consciousness
Nausea	Appears dazed
Balance problems or dizziness	Confused about play/assignment or forgets play/assignment
Blurred, double, or fuzzy vision	Unsure of game, score, or opponent
Sensitivity to light or noise	Clumsiness
Fogginess or grogginess	Slowly responds to questions
Drowsiness or sluggishness	Slurred speech
Concentration or memory problems	Behavior or personality changes
Confusion	Can't recall events prior to or after injury
	Seizures or convulsions
	Vacant facial expression

What can happen if my child keeps on playing with a concussion or returns too soon?

A student-athlete with the signs/symptoms of a concussion should be removed from play immediately. Continuing to play with the signs/symptoms of a concussion leaves the student-athlete vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after a concussion occurs, particularly if the student-athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. Student-athletes sometimes fail to report injury symptoms. Concussions are no different. Education of administrators, coaches, parents and students is the key to the safety of student-athletes.

Return to Play (RTP) Policy

Any student-athlete suspected of suffering a concussion should immediately be removed from play. No student-athlete may return to play after a concussion without medical clearance, regardless of how mild it seems or how quickly symptoms clear. Close observation of the student-athlete should continue for several hours. IHSA Policy states that a student-athlete removed from an interscholastic contest or practice due to a possible concussion, and not cleared to return to that same contest or practice, is required to provide the school with written clearance from either of the medical professionals listed below.

1. Physician licensed to practice medicine in all its branches
2. Certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches

In accordance with Public Act 097-0204, all schools are required to follow IHSA policy. As members of SIJHSAA, Tri-County Conference, and IESA, we follow the Rules of Play as adopted by IHSA.

Inform the coach if you think your child may have a concussion. It is better to miss one game than to miss the whole season.
"When in doubt, the student-athlete sits out."

For information on concussions and Public Act 097-0204, please go to:

<http://ihsa.org/Resources/SportsMedicine/ConcussionManagement/ParentGuardianResources.aspx>

Your signature, below, indicates that you have read the information above and are aware of the school's concussion policy. Both signatures are required before the student-athlete will be permitted to participate in any District 90 athletic activity.

 Name of Student-Athlete (Printed)

 Student-Athlete Signature

 Date

Student's Grade Level: _____

 Name of Parent or Legal Guardian (Printed)

 Parent or Legal Guardian Signature

 Date



■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

- ☐ Medically eligible for all sports without restriction
- ☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

- _____
- _____
- ☐ Medically eligible for certain sports

- _____
- ☐ Not medically eligible pending further evaluation
- ☐ Not medically eligible for any sports

Recommendations: _____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

Medications: _____

Other information: _____

Emergency contacts: _____



■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). _____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		



■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- Consider additional questions on more-sensitive issues.
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat - Pupils equal - Hearing		
Lymph nodes		
Heart ^a Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional Double-leg squat test, single-leg squat test, and box drop or step drop test		

^a Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA



State of Illinois
Certificate of Child Health Examination

Student's Name				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#					
Last		First		Middle		Month/Day/Year						
Address				Parent/Guardian		Telephone # Home Work						
IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <u>every</u> dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.												
REQUIRED Vaccine / Dose	DOSE 1		DOSE 2		DOSE 3		DOSE 4		DOSE 5		DOSE 6	
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP												
Tdap: Td or Pediatric DT (Check specific type)	☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT	
Polio (Check specific type)	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
Hib Haemophilus influenza type b												
Pneumococcal Conjugate												
Hepatitis B												
MMR Measles Mumps, Rubella							Comments:					
Varicella (Chickenpox)												
Meningococcal conjugate (MCV4)												
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose												
Hepatitis A												
IPV												
Influenza												
Other: Specify Immunization Administered/Dates												
Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.												
Signature				Title				Date				
Signature				Title				Date				
ALTERNATIVE PROOF OF IMMUNITY												
1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. *MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR												
2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease. Date of Disease Signature Title												
3. Laboratory Evidence of Immunity (check one) ☐ Measles* ☐ Mumps** ☐ Rubella ☐ Varicella Attach copy of lab result. *All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.												
Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____ Physician Statements of Immunity MUST be submitted to IDPH for review.												

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Last			First			Middle			Birth Date Month/Day/Year			Sex		School		Grade Level/ ID			
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER																			
ALLERGIES (Food, drug, insect, other)			Yes No		List:			MEDICATION (Prescribed or taken on a regular basis)			Yes No		List:						
Diagnosis of asthma?			Yes No		Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)			Yes No								
Child wakes during night coughing?			Yes No		Yes No			Hospitalizations? When? What for?			Yes No								
Birth defects?			Yes No		Yes No			Surgery? (List all.) When? What for?			Yes No								
Developmental delay?			Yes No		Yes No			Serious injury or illness?			Yes No								
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes No		Yes No			TB skin test positive (past/present)?			Yes* No		*If yes, refer to local health department.						
Diabetes?			Yes No		Yes No			TB disease (past or present)?			Yes* No								
Head injury/Concussion/Passed out?			Yes No		Yes No			Tobacco use (type, frequency)?			Yes No								
Seizures? What are they like?			Yes No		Yes No			Alcohol/Drug use?			Yes No								
Heart problem/Shortness of breath?			Yes No		Yes No			Family history of sudden death before age 50? (Cause?)			Yes No								
Heart murmur/High blood pressure?			Yes No		Yes No			Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other											
Dizziness or chest pain with exercise?			Yes No		Yes No			Information may be shared with appropriate personnel for health and educational purposes.											
Eye/Vision problems? ☐ Glasses ☐ Contacts ☐ Last exam by eye doctor ☐								Parent/Guardian Signature					Date						
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)																			
Ear/Hearing problems?			Yes No		Yes No														
Bone/Joint problem/injury/scoliosis?			Yes No		Yes No														
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA																			
HEAD CIRCUMFERENCE if < 2-3 years old						HEIGHT			WEIGHT			BMI			B/P				
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI > 85% age/sex Yes ☐ No ☐ And any two of the following: Family History Yes ☐ No ☐ Ethnic Minority Yes ☐ No ☐ Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes ☐ No ☐ At Risk Yes ☐ No ☐																			
LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.) Questionnaire Administered? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ Blood Test Date Result																			
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/od/oc/media/factsheets/testing/tb_testing.htm . No test needed ☐ Test performed ☐ Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____ Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value _____																			
LAB TESTS (Recommended)			Date			Results			Date			Results							
Hemoglobin or Hematocrit									Sickle Cell (when indicated)										
Urinalysis									Developmental Screening Tool										
SYSTEM REVIEW		Normal		Comments/Follow-up/Needs						Normal		Comments/Follow-up/Needs							
Skin										Endocrine									
Ears				Screening Result:						Gastrointestinal									
Eyes				Screening Result:						Genito-Urinary				LMP					
Nose										Neurological									
Throat										Musculoskeletal									
Mouth/Dental										Spinal Exam									
Cardiovascular/HTN										Nutritional status									
Respiratory				☐ Diagnosis of Asthma						Mental Health									
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)																			
NEEDS/MODIFICATIONS required in the school setting									DIETARY Needs/Restrictions										
SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup																			
MENTAL HEALTH/OTHER Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal																			
EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes ☐ No ☐ If yes, please describe.																			
On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified please attach explanation.) PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐																			
Print Name						(MD, DO, APN, PA) Signature						Date							
Address												Phone							