MARIAN CATHOLIC

Sports Medicine

Attention all parents / guardians, students, and athletes:

Please made note of the sheets below for **2026-2027** students and athletes. We recommend that you print and retain all pages for your information and records.

Parent Athletic/ Medical Awareness: Though enrollment at Marian Catholic, you have acknowledged that you have read and understand the forms on the Marian Catholic website ATHELTICS page that refer to Concussion information, protocol and SWAY Medical baseline/ post-injury program, IHSA Performance- Enhancing Substance Testing Policy, Return to Learn, Return to Play policies and Athletic Insurance/Medical Consent policies.

This acknowledgement **AND** a completed current copy of a Marian/ Doctor's/ IHSA physical form (necessary to supply **EACH** academic year) must be filed in the Athletics Office prior to trying out or competing with a Marian Catholic athletic team.

Once again for the **2026-2027** school year, Marian Catholic High School Sports Medicine Department will be utilizing the SWAY Medical Concussion baseline/ post-injury Program. This program is a computerized neurocognitive assessment tool, which can assist health care professionals, including athletic trainers, in the diagnosis, treatment, and progression of closed head and traumatic brain injuries i.e.: concussion.

Health Information Portability and Accountability Act of 1996 (HIPAA) regulations provide federal protection for personal health information held by covered entities. HIPAA establishes standards to safeguard the patients' protected heath information.

Through your acknowledgement, you will be releasing all necessary health information, old and new Sway Medical information to the Marian Catholic High School Sports Medicine Department for the purpose of assessment, treatment, and progression of your student-athletes medical related matters.

Thank you in advance for your cooperation,

Marian Catholic Athletics, and Sports Medicine

MARIAN CATHOLIC

Sports Medicine/Athletics - POLICIES

INSURANCE: All students who participate in interscholastic athletics at "Marian Catholic High School" MUST carry health insurance. The primary carrier is the Parent's Health Benefit and Major Medical Coverage. All claims should be processed through the primary carrier.

HOLD HARMLESS: I/we, as parent(s)/guardian(s) of the student, acknowledge that there is an inherent danger of injury or death when participating in athletics. I/we release Marian Catholic High School and its employees (Contracted Employees) from any liability accruing from our student's participation in athletics. In the event of accident, emergency, or illness I/we cannot be reached immediately; I/we hereby authorize the coach, athletic trainer, or administrator in charge to provide such first aid deemed necessary and advisable.

HOSPITAL: If, in the judgement of school authorities, physician/medical personnel are needed, and the parent(s)/ guardian(s) cannot be contacted, school authorities will call the Chicago Heights Fire Department for paramedic assistance. Students will typically be transported to ST JAMES HOSPITAL (20201 Crawford Ave. – Olympia Fields, Illinois) if that type of care is determined. If transportation is needed, I/we as parent(s)/guardian(s) of said student, agree that the named student may be transported in a privately owned vehicle, or in a commercial vehicle, i.e., taxi or ambulance. I/we, as parent (s)/ guardian (s) of named student, agree to assume all responsibility and expenses, including transportation incurred by the handling of emergency care.

STUDENT ACKNOWLEDGEMENT and AGREEMENT: As a prerequisite to participation in IHSA athletic activities, I agree that I will not use banned substances, including but not limited to performance enhancing substances, as defined in the IHSA Performance-Enhancing Substance Testing Program Protocol and policy of the school, ("banned substances"). It is my responsibility to review and understand the IHSA protocol and school policy. I have read this form and understand that I may be asked to submit to testing for the presence of banned substances in my body, and I do here by agree to submit to such testing and analysis by a certified laboratory selected by the school. I understand the testing may occur during the selected IHSA, state series events, or during the school day. I further understand, and agree that the results of the band substance testing may be provided to certain individuals in my high school. I understand and agree that the results of the band substance testing will be held confidential to the extent required by law. I understand the failure to provide accurate and truthful information could subject me to penalties as determined by the IHSA and/or the school.

PARENT/GUARDIAN CERTIFICATION AND ACKNOWLEDGEMENT: As a prerequisite to participation by my student, in IHSA athletic activities, I certify and acknowledge that I have read this form and understand that my student must refrain from banned substance use, and may be asked to submit to testing for the presence of banned substances in his/her body. I understand and agree that testing may occur during selected IHSA state series events, or during the school day. I do here by consent and submit my child to such testing and analysis by a certified laboratory selected by the school. I further understand and agree that the results of the band substance testing may be provided to certain individuals in the school. I understand and agree that the results of the band substance testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject my student to penalties as determined by the IHSA and/or the school.

PHOTOGRAPGY/VIDEOGRAPHY CONSENT—REMINDER: Parent(s)/Guardian(s) signatures on the original school registration form apply for use of photographs/videos from athletic contests for the duration of the student's involvement.

CONSENT TO TREAT AND AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I/we as parent/guardian of the identified student, authorize and consent to necessary treatment/care, as determined by the Certified and Licensed Athletic Trainer. I/we understand a continuing responsibility to report all injuries, or illnesses immediately to the athletic trainer, and to follow the direction of the physician, athletic trainer, and coach concerning the prevention, treatment, and rehabilitation of injuries. It is understood that if there is a need to be seen by a physician appropriate care is sought, and if insurance requires prior approval, it will be the responsibility of the family to acquire this and notify the physician.

This notice authorizes the release of any and all necessary information regarding any medical treatment received by for injury or illness while participating in extracurricular activities. The Sports Medicine Team is authorized to release said information to Physicians, Marian Catholic High School's administration, and to current coaching staff members for the purpose of informing them of the injury details, and playing status of the individual. The Sports Medicine Team may disclose information to the aforementioned individuals as it relates to care; however, this does not prevent those individuals from disclosing the information further, and the Sports Medicine Team will not be held responsible for such disclosure information. Participation in sport at Marian Catholic High School shall be considered as valid authorization, and is valid until and unless, revoked by me in writing

Sports Medicine/Athletics – POLICIES (cont.)

IHSA – Performance Enhancing Substances

The Illinois High School Association has a clear policy in regard to Performance Enhancing Substances, to which Marian Catholic High School strictly adheres. Please use the following resources to familiarize yourself with the IHSA Policy, and the various Position Statements from the National Federation of High Schools

IHSA Performance – Enhancing Substance Policy/ NFHS Position Statements on Appearance and Performance Enhancing Drugs and Substances, Supplements, and Anabolic Steroids:

https://www.ihsa.org/Resources/Sports-Medicine/Performance-Enhancing-Drugs-Steroid-Education

https://www.ihsa.org/documents/sportsMedicine/current/PES%20policy.pdf

Consent to Administer and Self-Administer Asthma Medication, Epinephrine Injections, Emergency Medications

Illinois Statute Chapter 105 School Code 5/22-30 provides direction for schools concerning the self-carry and self-administration of asthma medication and epinephrine injectors by students, and emergency use of asthma medication, epinephrine injectors, and opioid antagonists by trained personnel.

- For prescription medications, complete the Marian Catholic High School prescription medication form found on Marian Catholic's Sports Medicine web page. Form must be completed and submitted with IHSA physical annually.
- All prescription medication must be labeled and contain the name of the medication and the medication parameters including dosage, circumstances and/ or times medication should be administered.

A full copy of the law can be found at:
https://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=010500050K22-30

IHSA Sports Medicine Acknowledgement & Consent Form

Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are 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. They can range from mild to severe and can 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.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

- Headaches
- "Pressure in head"
- Nausea or vomiting
- Neck pain
- Balance problems or dizziness
- Blurred, double, or fuzzy vision
- Sensitivity to light or noise
- Feeling sluggish or slowed down
- Feeling foggy or groggy
- Drowsiness
- Change in sleep patterns
- Amnesia
- "Don't feel right"
- Fatigue or low energy
- Sadness
- Nervousness or anxiety
- Irritability
- More emotional
- Confusion
- Concentration or memory problems (forgetting game plays)
- Repeating the same question/comment

Signs observed by teammates, parents and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays incoordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can't recall events prior to hit
- Can't recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness

IHSA Sports Medicine Acknowledgement & Consent Form

Concussion Information Sheet (Cont.)

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

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The Youth Sports Concussion Safety Act requires athletes to complete the Return to Play (RTP) protocols for their school prior to returning to play or practice following a concussion or after being removed from an interscholastic contest due to a possible head injury or concussion and not cleared to return to that same contest.

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
http://www.cdc.gov/ConcussionInYouthSports/

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 7/1/2011 Reviewed 4/24/2013, 7/16/2015, July 2017

IHSA Sports Medicine Acknowledgement & Consent Form

IHSA Performance-Enhancing Substance Policy

In 2008, the IHSA Board of Directors established the association's Performance-Enhancing Substance (PES) Policy. A full copy of the policy and other related resources can be accessed on the IHSA Sports Medicine website. Additionally, links to the PES Policy and the association's Banned Drug classes are listed below. School administrators are able to access the necessary resources used for policy implementation in the IHSA Schools Center.

As a prerequisite to participation in IHSA athletic activities, we have reviewed the policy agree that I/our student will not use performance-enhancing substances as defined by the policy. We understand that failure to follow the policy could result in penalties being assigned to me/our student either by the my/our student's school or the IHSA.

IHSA PES Policy
http://www.ihsa.org/documents/sportsMedicine/2017-18/2017-18 PES policy.pdf

IHSA Banned Drug Classes
http://www.ihsa.org/documents/sportsMedicine/current/IHSA Banned Drugs.pdf

MARIAN CATHOLIC

Sports Medicine Consent Form to Self-Administer Prescription Medication

Parent Consent

I, _____, do herby give my child _____, permission to self-administer their prescription medication as prescribed by their physician during athletic participation.

_____ _____

Signature of Parent/Guardian

Prescription Details

Patient Name: _____ DOB: _____

Medication: _____

Purpose: _____

Dosage: _____

Time/ Special Circumstances: _____

Patient Name: _____ DOB: _____

Medication: _____

Purpose: _____

Dosage: _____

Time/ Special Circumstances: _____

Physician Details

Physician Name: _____

Contact Information: _____

Physician Signature: _____

Date: _____

Physician Stamp

MARIAN CATHOLIC

MARIAN CATHOLIC HIGH SCHOOL PROTOCOL FOR RETURN TO LEARN (RTL)

Instructions: *Each concussion is evaluated, treated, accommodated on a case-by-case basis. Not all stages are required to be used for each injury/individual. Some Stages might not be used based on patient condition*.

- Keep brain activity below a level that does not causes a significant exacerbation of symptoms.
- If symptoms worsen, modify/decrease activity level
- Specialized/additional physicians/treatments might be required if your child does not show improvement in symptoms
- Provide all medical documentation and forms to the school's concussion oversight team to provide appropriate care.

Stage	Home Activity	School Activity	Physical Activity
Restful Activity	Rest/relax, nap and sleep as much as needed. Avoid bright light if bothersome. Drink plenty of fluids and eat healthy foods every 3-4 hours. Avoid "screen time" (i.e., cell phone, computer, TV, tablet and video games)	Limit to what is tolerated by individual. Avoid activities that cause increase in symptoms.	Limit to what is tolerated by individual, walking short distances with plenty of time for breaks. No exercise or sport activities of any kind. No Driving.
	Increase BRAIN activity as tolerated, accommodations for classwork are provided by a Physician with guidance of Concussion Oversight Team		
Return to school - (with accommodations)	Rest/relax, allow 8-10 hours of sleep per night. Drink plenty of fluids and eat healthy foods every 3-4 hours. Limit "screen time" to what is required for school work. Limit loud environments and social time with friends outside of school.	Physician completes MCHS School Accommodations form with guidance of Concussion Oversight Team	No strenuous physical activity or contact sports. No Driving.
	Increase BRAIN activity as tolerated, accommodations for classwork are provided by a Physician with guidance of Concussion Oversight Team		
Return to school - (without accommodations)	Return to normal home and social activities	Complete all assignments/ tests without accommodations.	No strenuous physical activity or contact sports.
	Upon completion of this stage, and symptom free, patient can begin Return to Play Protocol.		

MARIAN CATHOLIC

Physician Recommended School Academic Accommodations Following Concussion (RTL Protocol)

Patient Name:_____ DOB:_____

I, _____, give my permission for my physician to share the following information with my child's school and for communication to occur between the school and my physician for changes to this plan.

Parent/Guardian Signature: _____

Physician Name and Contact Information: _____

Physician Signature: _____ Date: _____

This patient will be reevaluated in_____ weeks/days.

Physician Stamp

This patient has been diagnosed with a concussion (a brain injury) and is currently under our care. Please excuse the patient from school today due to the medical appointment. Flexibility and additional supports are needed during recovery. The following are suggestions for academic adjustments to be individualized for the student as deemed appropriate in the school setting. Adjustments can be modified as the student's symptoms improve/worsen

Area	Requested Modifications	Comments
Attendance	☐ NO SCHOOL ☐ Partial school days as tolerated by student—Emphasis on core subject work ☐ Full school day as tolerated by student ☐ Water bottle in class/snack every 3-4 hours ☐ Other:_____	
Breaks	☐ If symptoms appear/ worsen during class, allow student to go to quiet area ☐ Allow breaks during day as deemed necessary by student or teachers/personnel ☐ Other:_____	
Visual Stimulus	☐ Limited computer, TV screen, Tablet, bright screen use ☐ Allow handwritten assignments (vs. Tablet/Computer) ☐ Allow student to wear sunglasses in school; seat student away from windows and bright lights ☐ Other:_____	
Auditory Stimulus	☐ Avoid loud classroom activities ☐ Lunch in quiet place with a friend ☐ Avoid loud class/places (band, gym, cafeteria) ☐ Allow student to wear earplugs as needed ☐ Other:_____	
School Work	☐ Simplify Tasks (i.e., 3 step instructions) ☐ Short breaks (5 minute) between tasks ☐ Reduce overall amount of in-class work ☐ Prorate workload (only core or important tasks)/eliminate non-essential work ☐ No homework ☐ Reduce amount of nightly homework. (_____min/class) ☐ Will attempt homework, but will stop if symptoms occur ☐ Extra tutoring/assistance requested ☐ Other:_____	
Testing	☐ No Testing ☐ Additional time for testing/untimed testing ☐ Alternative testing methods (oral delivery of questions, oral response, or scribe) ☐ Other:_____	
Education Plan	☐ Student is in need of a specialized education plan (IEP), for prolonged symptoms lasting >3 months, if interfering with academic performance	
Physical Activity	☐ No physical exertion/ athletics/ gym class ☐ Walking in PE class only ☐ May begin guided Return to Play (RTP) following MCHS RTP Protocol	

*Adapted from CIF Physician Recommended School Accommodations Following Concussion

MARIAN CATHOLIC

Physician Recommended Return to Participation (RTP) Following Concussion

Patient Name:_____ DOB:_____

I, _____, give my permission for my physician to share the following information with my child's school and for communication to occur between the school and my physician for changes to this plan.

Parent/Guardian Signature: _____

Physician Name and Contact Information: _____

Physician Signature: _____ Date: _____

This patient will be reevaluated in_____ weeks/days.

Physician Stamp

Injury Status
☐ Has been diagnosed by a physician with a concussion and is under our care. Medical follow-up evaluation is scheduled for (date):_____
☐ Was evaluated and did not have a concussion injury. There are no limitations on school and physical activity

Physical Activity Status
☐ Restricted from all physical activity
☐ Complete MCHS Return to Participation (RTP) Protocol
☐ Fully cleared, No restrictions
☐ Other:_____

RTP Protocol

Stage 1 of the RTP protocol can begin after completion of RTL protocol and symptom free for 24-48 hours. Once concussion related symptoms have resolved, and the student-athlete has returned to a baseline state of any neurocognitive tests they were administered (if applicable), the remainder of RTP Protocol [Stages 2-6] can begin. Final written clearance from an appropriate healthcare provider as dictated by the state concussion law must be obtained before returning to contact practice and unrestricted participation. There will be 24 hours in between each stage of the progression. If any symptoms worsen during guided protocol exercises, the student-athlete should stop activity for the day. After remaining symptom-free for 24 hours, the student-athlete should return to the previous stage and attempt to complete this stage again without reoccurrence of symptoms.

Stage	Aim	Activity	Goal
1	Symptom limited activity	Daily Activities that do not provoke symptoms. Completion of RTL protocol	Gradual re-introduction of school activities
2	Light Aerobic Activity	Walking, stationary bike slow to medium pace. No resistance training. (Approx. 15 minutes-30 minutes)	Increase heart rate
3	Sport-Specific Activity	Running drills, No head impact activities (Approx. 30 minutes-1 hour)	Add dynamic movement
4	Non-Contact Training Drills	Harder training drills, May start progressive resistance training	Exercise, coordination, and increased thinking
5	Full Contact Practice	Following medical clearance, participate in normal activities	Restore confidence and assess functional skills by coaching staff
6	Return to Sport	Normal Game play	

McCrory, P., et al (2017). Consensus statement on concussion in sport – the 5th international conference on concussion in sport held in Berlin, October 2016. *British Journal of Sports Medicine*. Published Online First: 26 April 2017.

By Signing this, I understand and will comply with Marian Catholic High School's Concussion Return to Participation Policy.

_____ _____ _____

Student-Athlete Name | Student-Athlete Signature | Date

_____ _____ _____

Parent/Guardian Name | Parent/Guardian Signature | Date

MARIAN CATHOLIC

Post-concussion Consent Form (RTP/RTL)

Date _____

Student's Name _____ **Year in School** 9 10 11 12

By signing below, I acknowledge the following:

1. I have been informed concerning and consent to my student's participating in returning to play in accordance with the return-to-play and return-to-learn protocols established by Illinois State law;
2. I understand the risks associated with my student returning to play and returning to learn and will comply with any ongoing requirements in the return-to-play and return-to-learn protocols established by Illinois State law;
3. And I consent to the disclosure to appropriate persons, consistent with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), the written statement of the treating physician, athletic trainer, advanced practice nurse (APN), or physician assistant (PA) and, if any, the return-to-play and return-to-learn recommendations of the treating physician, athletic trainer, advanced practice nurse (APN), or physician assistant (PA), as the case may be.

Student's Signature _____

Parent/Guardian's Name _____

Parent/Guardian/s Signature _____

For School Use only

☐ Written statement is included with this consent from treating physician, advanced practice nurse (APN), physician assistant (PA) or athletic trainer working under the supervision of a physician that indicates, in the individual's professional judgement, it is safe for the student to return-to-play and return-to-learn.

Cleared for RTL

Date _____

Cleared for RTP

Date _____

Updated September 2017