ORANGEVILLE CUSD #203

2017 - CONCUSSION PROTOCOL - 2018

Concussion Oversight Team Members

- **Physician** - TBA
- **Trainer** – Katie Benning
- **Administrator & Return to Learn** – Andrew Janecke, Jr.-Sr. High Principal & William Guy, Athletic Director
- **School Nurse** – Kathy Sheriff
- **Coach** – Toby Golembiewski, Physical Education Teacher

Before Start of Athletic Seasons

The concussion oversite team will review this plan and sign off on the final page.

Before Participation

- A student may not participate in an interscholastic athletic activity until the student and the student's parent have signed a form acknowledging receiving and reading information that explains "concussion prevention, symptoms, treatment, and oversight and that includes guidelines for safely returning to participation in an athletic activity following a concussion." This form must be approved by the Illinois High School Association.
- A student must also sign the Post-Concussion Consent Form.

Start of Season

All coaches must complete IHSA concussion training and show the IHSA concussion video to their team at the start of each season.

During Season

- A student must be removed from interscholastic athletic practices or competition immediately if a coach, physician, game official, athletic trainer, parent, student or other person deemed appropriate under the school's return-to-play protocol believes that the student may have suffered a concussion.
- A student removed from competition or practice due to a possible concussion may not play or practice again until all of the following have been met:
    - The student has been evaluated by the student's physician or an athletic trainer working under the supervision of a physician and it have been determined that the student can safely return to play and return to learn.
    - The student has completed all requirements of the school's return-to-play protocol and return-to-learn protocol.
    - The student's parent acknowledge that the student has completed the return-to-play and return-to-learn protocols. The student's parent must provide the physician's report to the individual at the school responsible for implementing the return-to-play and return-to-learn protocols.

- The student's parent signs a consent form indicating that the parent has been informed of physician's report and consents to the student's return to play. The consent form must also indicate the parent understands the risks associated with a return to play and return to learn and will comply with ongoing return-to-play and return-to-learn protocols and consents to sharing the physician's statement and any recommendations to appropriate persons.

At All Times

- The athletic director (unless that individual is a coach) will supervise the return-to-play and return-to-learn protocols. If the AD is a coach, the building principal will supervise the protocols.

RETURN-TO-LEARN PROTOCOL

A student removed from competition or practice due to a possible concussion may not return to learn again until all of the following have been met:

- The student has been evaluated by the student's physician or an athletic trainer under the supervision of a physician and it has been determined that the student can safely return to learn.
- The student's parent/guardian has acknowledged that the student has completed the return-to-learn protocols.
- The student's parent/guardian must provide documentation from the physician stating that the specific details for the student as he/she returns to learn.
    - This should include a timeline as well as any limitations or restrictions in terms of academic workload, PE participation, and interscholastic activities participation. If there are no limitations or restrictions, this documentation should state that the individual is ready to learn and/or ready to play without any limitations or restrictions.
- The parent/guardian must sign the consent form indicating that he/she has been informed of physician's report and consents to the student's return to play.
    - The student's parent/guardian signs a consent form indicating that the parent has been informed of physician's report and consents to the student's return to play.
- In collaboration with the parent/guardian, the building administrator will inform the student's teachers of the situation and make sure any necessary accommodations deemed necessary by the physician

RETURN-TO-PLAY PROTOCOL

A student removed from competition or practice due to a possible concussion may not play or practice again until all of the following have been met:

- The student has been evaluated by the student's physician or an athletic trainer under the supervision of a physician and it has been determined that the student can safely return to play and return to learn.
- Student must have completed the return-to-learn protocol.
- The student's parent/guardian has acknowledged that the student has completed the return-to-play and return-to-learn protocols.

- The student's parent/guardian must provide documentation from the physician stating that the specific details for the student as he/she returns to learn and returns to play.
    - This should include a timeline as well as any limitations or restrictions in terms of academic workload, PE participation, and interscholastic activities participation. If there are no limitations or restrictions, this documentation should state that the individual is ready to learn and/or ready to play without any limitations or restrictions.
- The parent/guardian must sign the consent form indicating that he/she has been informed of physician's report and consents to the student's return to play.
    - The student's parent/guardian signs a consent form indicating that the parent has been informed of physician's report and consents to the student's return to play.

CONSENT TO RETURN-TO-LEARN

Per the forms received and signed before the start of the season, I understand the risks associated with a return to play and return to learn and will comply with ongoing return-to-play and return-to-learn protocols. I give consent to share the physician's statement and any recommendations to individuals deemed appropriate by the school district. I give consent to allow my student to return to learn.

Parent Name (print): _____

Parent Signature: _____ Date: _____

Student Name (print): _____

Student Signature: _____ Date: _____

CONSENT TO RETURN-TO-PLAY

Per the forms received and signed before the start of the season, I understand the risks associated with a return to play and return to learn and will comply with ongoing return-to-play and return-to-learn protocols. I give consent to share the physician's statement and any recommendations to individuals deemed appropriate by the school district. I give consent to allow my student to return to play.

Parent Name (print): _____

Parent Signature: _____ Date: _____

Student Name (print): _____

Student Signature: _____ Date: _____

ORANGEVILLE CUSD #203

Interscholastic Athletic Activities Emergency Action Plan

In circumstances to address serious injuries and acute medical conditions in which the condition of the student may deteriorate rapidly, Orangeville CUSD #203 staff will take charge until the appropriate medical attention relives the staff members of their duties. The coaching staff and supervisor will be responsible for applying initial first aid. If an ambulance is deemed necessary, the supervisor on duty (if applicable) will call for the ambulance. If at a practice where there isn't a supervisor, a member of the coaching staff will make the call. A member of the coaching staff will grab the student's emergency card and call the appropriate contact. Each coaching staff will have a first aid kit with them at all practices and games to apply immediate first aid. An AED will also be on all sites. Emergency responders will drive to the scene if at the park. If the accident takes place at the school, the supervisor/coach will inform the responders of the nearest exit for them to park their vehicle. Furthermore, this individual will make sure there is clear path for the vehicle to get to this location to ensure that the individual is transported in the timeliest fashion possible.

ORANGEVILLE HIGH SCHOOL
EMERGENCY ACTION PLAN-ACCIDENTS OR INJURIES

Emergency Personnel

Athletic Trainers, Nurse, Athletic Director, Administration, Coaches

Emergency Communication/Chain of Command to Notify

Elementary School Principal/Superintendent: Dr. Douglas Deschepper
Athletic Trainer: Katie Benning
Athletic Director: Willi Guy
High School Principal: Andrew Janecke

Emergency Equipment

AED's are located in the ***main lobby of the high school***, in the ***lower level of the press box*** (during football season, July-October) and in the ***ball field concession stand building*** (during ball season, April-July.)

All coaches will have a first aid kit and ice available. Additional ice can be obtained from the ice machine, in the lower level of the high school across from the janitorial office.

Athlete emergency Notification cards are located in high school office**.**

Roles of First on Scene

Control the scene/gain access to athlete.
Initial Assessment-determine breathing, pulse, and consciousness.
Detailed assessment-determine extent of illness/injury.
Send a coach or staff member to summon help if needed.
EMS-Call 911
Athletic Trainer: Katie Benning

Initiate immediate care to injured/ill athlete**.**

Coach, Athletic Trainer, or Administration will pull Emergency card and contact athlete's parents.

ORANGEVILLE CUSD #203

Activation of EMS

Call 911 if:

An athlete is not breathing or has lost consciousness.
It is suspected that an athlete may have a neck or back injury.
An athlete has an open fracture (bone has punctured through the skin.)
Severe heat exhaustion or suspected heat stroke.
Severe bleeding that cannot be stopped.

Have a designated person meet ambulance and direct to scene.

Document Incident

Document incident in writing as soon as possible after the incident.

Venue Directions

Address: 310 S. East St. Phone:815-789-4289
Football Field-Behind Orangeville High School.
Ball Diamonds-Behind Orangeville High School.
Basketball/Volleyball-Orangeville High School gym. Entrance is through Main lobby.

EMERGENCY CONTACT LIST

Ambulance:911
Stephenson County Police:815-235-8252
Orangeville Fire Dept:911
Poison Center:1-800-222-1212

Other Contacts

Athletic Director Willi Guy 815-291-7253	Athletic Trainer Katie Benning 608-325-7529
Nurse Kathy Sheriff 815-904-2717	

The above Emergency Contacts will be responsible for contacting Administration as needed.

Orangeville Jr-Sr High School 815-789-4289	
Principal	Andrew Janecke
HS & MS Athletic Director	William Guy
Head Football Coach	Jay Doyle
Head Volleyball Coach	TBA
Head Boys' Basketball Coach	Jesse Stamm

ORANGEVILLE CUSD #203

Head Girls' Basketball Coach	Steve Picavet
Head Softball Coach	Lon Scheuerell
Head Baseball Coach	Bill Meier
Jr. High Football Coach	Ryan Smith
Jr. High Volleyball Coach	Liz Hazzard
Jr. High Boys' Basketball Coach	Jay Doyle
Jr. High Girls' Basketball Coach	Joe Edler

CONCUSSION EVALUATION FORM

Student's Name: _____ **Date of Injury:** _____

Location of injury: _____ **Sport:** _____

Brief Description of Incident: _____

_____

_____

Symptoms at Time of Injury: _____

_____

_____

Change in Symptoms: _____

_____

_____

Certified Athletic Trainer or other reporting Physician: _____

Contact Information: _____

Common Signs and Symptoms of Concussions:

- Athlete appears dazed
- Confusion
- Memory loss
- Forgetfulness
- Loss of Balance
- Loss of Consciousness
- Change in Behavior
- Difficulty with Concentration
- Headache
- "Pressure" in Head
- Nausea or Vomiting
- Dizziness
- Blurred or Double Vision
- Sensitivity to Light
- Sensitivity to Noise
- Feeling "sluggish"

Avoid:

- Bright lights
- Loud noises
- Television
- Computers
- Texting
- Video Games
- Homework
- Anything else that intensifies symptoms

Seek Medical Attention Immediately If:

- Symptoms become worse
- Any loss of consciousness
- Irregular change in respiration
- Seizures or convulsions
- Bleeding is noticed
- Slurred speech
- Repeated vomiting

I. RECOGNITION OF A CONCUSSION

a. Common signs and symptoms of sports-related concussion:

i. Signs (observed by others):

- Athlete appears dazed or stunned
- Confusion (about assignment, plays, etc.)
- Forgets plays
- Unsure about game, score, opponent
- Moves clumsily (altered coordination)
- Balance problems
- Personality change
- Responds slowly to questions
- Forgets events prior to hit
- Forgets events after the hit
- Loss of consciousness (any duration)

ii. Symptoms (reported by athlete):

- Headache
- Fatigue
- Nausea or vomiting
- Double vision, blurry vision
- Sensitive to light or noise
- Feels sluggish
- Feels "foggy"
- Problems concentrating

- Problems remembering

iii. These signs and symptoms are indicative of probable concussion. Other possible causes for these symptoms should also be considered.

b. Cognitive impairment (altered or diminished cognitive function

i. General cognitive status can be determined by simple sideline cognitive testing.

ii. AT (Athletic Trainer) may utilize SCAT (Sports Concussion Assessment Tool), or other standard tool for sideline cognitive testing.

II. MANAGEMENT AND REFERRAL GUIDELINES FOR ALL STAFF

a. Suggested Guidelines for Management of Sports-Related Concussion

i. Any athlete with a witnessed LOC (loss of consciousness) of any duration should be transported immediately to nearest emergency department.

ii. Any athlete who has symptoms of a concussion and is not stable (i.e., condition is changing or deteriorating), is to be transported immediately to the nearest emergency department.

iii. An athlete who exhibits <u>any</u> of the following symptoms should be transported immediately to the nearest emergency department.

1. deterioration of neurological function
2. decreasing level of consciousness
3. decrease or irregularity in respirations
4. decrease or irregularity in pulse
5. unequal, dilated, or unreactive pupils
6. any signs or symptoms of associated injuries, spine or skull fracture, or bleeding
7. mental status changes: lethargy, difficulty maintaining arousal, confusion or agitation
8. seizure activity
9. cranial nerve deficits

iv. An athlete who is symptomatic but stable, may be transported by his or her parent/guardian. The parent/guardian should be advised to contact the athlete's primary care physician, or seek care at the nearest emergency department, on the day of the injury.

1. ALWAYS give parents the option of emergency transportation, even if you do not feel it is necessary.

III. PROCEDURES FOR THE CERTIFIED ATHLETIC TRAINER *(if available)*

a. The ATC will assess the injury, or provide guidance to the coach if unable to personally attend to the athlete.

b. Immediate referral to the athlete's primary care physician or to the hospital will be made when medically appropriate (see section II).

c. The ATC will perform serial assessments, and utilize the SCAT (Sport Concussion Assessment Tool) or ImPact.

i. The Athletic Trainer will notify the athlete's parents and give written and verbal home and follow-up care instructions if a concussion is determined.

1. Follow-up care instructions vary by case but generally include:

a. Monitoring symptoms and seek medical attention is symptoms worsen

b. Do not allow individuals with concussions to operate heavy machinery (including but not limited to driving a car)

c. Avoiding bright lights, loud noises, electronics (including but not limited to TV, cell phones, video games)

d. Avoiding mind strenuous activities and other activities that intensify symptoms

IV. GUIDELINES AND PROCEDURES FOR COACHES

RECOGNIZE, REMOVE, REFER

a. **Recognize** concussion

i. All coaches should become familiar with the signs and symptoms of concussion that are described in Section I.

ii. Very basic cognitive testing should be performed to determine cognitive deficits (i.e. what quarter it is, are you on offense/defense, name, date, what school they are playing, what they ate that day).

b. **Remove** from activity

i. If a coach suspects the athlete has sustained a concussion, the athlete should be removed from activity until evaluated medically.

1. **Any athlete who exhibits signs or symptoms of a concussion should be removed immediately, assessed, and SHOULD NOT be allowed to return to activity that day unless assessed and cleared by an ATC or physician.**

2. **When in doubt, keep them out.**

c. **Refer** the athlete for medical evaluation

i. Coaches should report all head injuries to the ATC, as soon as possible, for medical assessment and management, and for coordination of home instructions and follow-up care.

ii. Coaches should seek assistance from the host site AT if at an away contest.

iii. If the AT is unavailable, or the athlete is injured at an away event, the coach is responsible for notifying the athlete's parents of the injury.

1. Contact the parents to inform them of the injury and make arrangements for them to pick the athlete up at school.
2. Contact the AT with the athlete's name and home phone number, so that follow-up can be initiated.
3. Remind the athlete to report directly to the AT on the day he or she returns to school after the injury.

iv. In the event that an athlete's parents cannot be reached, and the athlete is able to be sent home (rather than directly to MD):

1. The Coach or AT should insure that the athlete will be with a responsible individual, who is capable of monitoring the athlete and understanding the home care instructions, before allowing the athlete to go home.
2. The Coach or AT should continue efforts to reach the parent/guardian.
3. If there is any question about the status of the athlete, or if the athlete is not able to be monitored appropriately, the athlete should be referred to the emergency department for evaluation. A coach or AT should accompany the athlete and remain with the athlete until the parents arrive.
4. Athletes with suspected head injuries should not be permitted to drive home.

V. RETURN TO PLAY (RTP) PROCEDURES

a. Returning to participate on the same day of injury

i. As previously discussed in this document, an athlete who exhibits signs or symptoms of concussion, or has abnormal cognitive testing, should not be permitted to return to play on the day of the injury. Any athlete who denies symptoms but has abnormal sideline cognitive testing should be held out of activity. **"When in doubt, hold them out."**

ii. If a collision occurs and contact with the head is sustained, only qualified health care professionals, including athletic trainers can clear an athlete back to play on the day of suspected injury.

b. Return to play after concussion

i. The athlete must meet all of the following criteria in order to progress to activity:

1. Asymptomatic at rest and with exertion (including mental exertion in school) without the use of pain medication
2. Improved results of ImPact test to meet or exceed the score of the athlete's baseline or initial concussion test

ii. Once the above criteria are met, the athlete will be progressed back to full activity following a stepwise process, under the supervision of the ATC.

iii. Progression is individualized, and will be determined on a case by case basis. Factors that may affect the rate of progression include: previous history of concussion, duration and type of symptoms, age of the athlete, and sport/activity in

which the athlete participates. An athlete with a prior history of concussion, one who has had an extended duration of symptoms, or one who is participating in a collision or contact sport should be progressed more slowly.

iv. Stepwise progression supervised by the Certified Athletic Trainer:

1. No activity – do not progress to step 2 until asymptomatic
2. Light aerobic exercise – walking, stationary bike
3. Sport-specific training (e.g., skating in hockey, running in soccer)
4. Non-contact training drills
5. Full-contact training after medical clearance
6. Game play

Note: If the athlete experiences post-concussion symptoms during any phase, the athlete should drop back to the previous asymptomatic level and resume the progression after 24 hours.

v. The ATC and athlete will discuss appropriate activities for the day. The athlete will be given verbal instructions regarding permitted activities.

vi. The athlete should see the AT daily for re-assessment and instructions until he, or she, has progressed to unrestricted activity.

CONCUSSION PROTOCOL FOR 2017 - 2018 SCHOOL YEAR

Signatory Page

Principal's Name (print): _____

Principal's Signature: _____ Date: _____

Athletic Dir.'s Name (print): _____

Athletic Dir.'s Signature: _____ Date: _____

Physician's Name (print): _____

Physician's Signature: _____ Date: _____

Nurse's Name (print): _____

Nurse's Signature: _____ Date: _____

Coach's Name (print): _____

Coach's Signature: _____ Date: _____

APPENDIX A

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

APPENDIX A (continued)

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. IHSA Policy requires athletes to provide their school with written clearance from either a physician licensed to practice medicine in all its branches or a certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches 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. In accordance with state law, all IHSA member schools are required to follow this policy.

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

APPENDIX A (continued)

IHSA Performance-Enhancing Substance Testing Policy

In 2008, the IHSA Board of Directors established the association's Performance-Enhancing Substance (PES) Testing Program. Any student who participates in an IHSA-approved or sanctioned athletic event is subject to PES testing. A full copy of the testing program 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 program implementation in the IHSA Schools Center.

IHSA PES Testing Program

http://www.ihsa.org/documents/sportsMedicine/2014-15/2014-15%20PES%20policy%20final.pdf
IHSA Banned Drug Classes

http://www.ihsa.org/documents/sportsMedicine/2014-15/2014-15%20IHSA%20Banned%20Drugs.pdf

IHSA Steroid Testing Policy Consent to Random Testing

As a prerequisite to participation in IHSA athletic activities, we agree that I/our student will not use performance-enhancing substances as defined in the IHSA Performance-Enhancing Substance Testing Program Protocol. We have reviewed the policy and understand that I/our student may be asked to submit to testing for the presence of performance-enhancing substances in my/our student's body either during IHSA state series events or during the school day, and I/our student do/does hereby agree to submit to such testing and analysis by a certified laboratory. We further understand and agree that the results of the performance-enhancing substance testing may be provided to certain individuals in my/our student's high school as specified in the IHSA Performance-Enhancing Substance Testing Program Protocol which is available on the IHSA website at www.IHSA.org. We understand and agree that the results of the performance-enhancing substance testing will be held confidential to the extent required by law. We understand that failure to provide accurate and truthful information could subject me/our student to penalties as determined by IHSA.

A complete list of the current IHSA Banned Substance Classes can be accessed at

http://www.ihsa.org/documents/sportsMedicine/2015-16/2015-16%20IHSA%20Banned%20Drugs.pdf

APPENDIX A (continued)

IHSA Sports Medicine Acknowledgement & Consent Form

Acknowledgement and Consent

STUDENT / PARENT CONSENT AND ACKNOWLEDGEMENTS

ORANGEVILLE CUSD #203

By signing this form, we acknowledge we have been provided information regarding concussions and the IHSA Performance-Enhancing Testing Policy. We also acknowledge that we are providing consent to be tested in accordance with the procedures outlined in the IHSA Performance-Enhancing Testing Policy.

PARENT or LEGAL GUARDIAN

Parent Name (print): _____

Parent Signature: _____ Date: _____

STUDENT

Student Name (print): _____ Grade (6-12) _____

Student Signature: _____ Date: _____

CONSENT TO SELF-ADMINISTER ASTHMA MEDICATION

Illinois Public Act 098-0795 provides new directions for schools concerning the self-carry and self-administration of asthma medication by students. In order for students to carry and self-administer asthma medication, parents or guardians must provide schools with the following:

- Written authorization from a student's parents or guardians to allow the student to self-carry and self- administer the medication.
- The prescription label, which must contain the name of the asthma medication, the prescribed dosage, and the time at which or circumstances under which the asthma medication is to be administered.

A full copy of the law can be found at http://www.ilga.gov/legislation/publicacts/98/PDF/098-0795.pdf.

Each year IHSA member schools are required to keep a signed Acknowledgement and Consent form and a current Pre-participation Physical Examination on file for all student athletes.

APPENDIX B

PARENT / STUDENT ATHLETIC CONSENT FORM

Valid for the Following Dates: June 1, 2017 through July 31, 2018

ACKNOWLEDGEMENT OF RISK AND INSURANCE STATEMENT

ORANGEVILLE CUSD #203

(TO BE COMPLETED AND SIGNED BY PARENT / GUARDIAN)

I give permission for _____ (*Name of Child/Ward*) **CIRCLE THE SPORT(S) YOUR CHILD/WARD PLAN ON PARTICIPATING:** Baseball, Basketball, Cheerleading, Cross Country, Football, Golf, Softball, Strength & Conditioning (including weight training), Hockey, Track, Volleyball, Wrestling, Other (Identify Sports): _____

I am aware that with the participation in sports comes the risk of injury to my child/ward. I understand that the degree of danger and the seriousness of the risk vary significantly from one sport to another with contact sports carrying the higher risk. I understand the risk inherent in sports. He/she has athletic participation insurance coverage through the school (YES___NO___); he/she is insured by our family policy with:

PERSONAL / FAMILY INSURANCE INFORMATION

Name of Company: _____

Policy Number: _____

Name of Policy Holder: _____

I am aware that participating in sports will involve travel with the team. I acknowledge and accept the risks inherent in the sport and with the travel involved and with this knowledge in mind, grant permission for my child/ward to participate in the sport and travel with the team. Additionally, I give my consent and approval for the above named student's picture and name to be printed in any high school or association athletic program.

EMERGENCY PERMISSION FORM

STUDENT'S NAME: _____ **GRADE:** _____ **AGE:** _____

SCHOOL: _____ **CITY:** _____

Please list any health problems that your child has that might be significant to a physician evaluation or that someone providing supervision to the child should be aware of:

Please list any allergies to medications, etc.: _____

Has student been prescribed an inhaler or EpiPen? _____

Is student presently taking medication? _____ **If so what type?** _____

Is student allergic to bee stings? _____

Does student wear contact lenses? _____ **Please list date of last Tetanus shot:** _____

ORANGEVILLE CUSD #203

EMERGENCY AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby give permission to physicians selected by the coaches, staff, or volunteers of the Orangeville School District to hospitalize, secure proper treatment for, and to order injection/anesthesia, and/or surgery for the person named above.

Daytime Phone Number: (where to reach you in an emergency) (_____) _____ - _____

Evening Phone Number: (where to reach you in emergency) (_____) _____ - _____

Relationship to Student: _____

Emergency permission form may be reproduced to travel with respective teams and is acceptable for emergency treatment if needed. I certify all the above information is correct.

PARENT or LEGAL GUARDIAN

Parent Name (print): _____

Parent Signature: _____ Date: _____

STUDENT

Student Name (print): _____ Grade (7-12) _____

Student Signature: _____ Date: _____

PARENT & STUDENT ACKNOWLEDGMENT OF THE ATHLETIC HANDBOOK

I hereby acknowledge that I have received and read the West Carroll School District Athletic Handbook and understand the rules and regulations within. I agree to abide by all the rules and regulations set down by my individual coach and the athletic director.

I agree to assume full responsibility for all equipment issued to me, and to confine the use of that equipment to practice, games, or meets.

I will further agree to pay for any and all equipment, which I may lose, misplace, or damage through carelessness or intent.

Parent Name (print): _____

Parent Signature: _____ Date: _____

Student Name (print): _____

Student Signature: _____ Date: _____

APPENDIX B (continued)

ATHLETIC WAIVERS AND AGREEMENTS

Parent / Guardian: The following items are statements that require your reading and signature. Please check either yes or no for each statement.

Yes	No	
_____	_____	1. **Athletic Handbook:** The handbook will be distributed during the first days of practice and/or the first day of school. I/We acknowledge that I/we have received this handbook.
_____	_____	2. I/We intend to review the contents of the **Athletic Handbook**. It is my/our responsibility to read and review this document with my child.
_____	_____	3. **Photo Release:** The district from time to time allows coverage of activities and events. I/We give permission for our child's picture/video and name to be used in informational news coverage and educational purposes, including the District web site.
_____	_____	4. **Student Awards/Honor Information:** The district from time to time announces listings of students receiving awards and honors. I/We give permission for our child's name to be released for the purpose of identifying students who excel.
_____	_____	5. **Directory Information:** (name, address, phone number). I give permission to release this information for school related purposes
_____	_____	6. **Insurance:** All children participating in interscholastic sports or activities must be covered under a health and accident policy. As a parent/guardian of _____, I do hereby certify that my child is currently covered under a Health and accident policy as mentioned above.
_____	_____	7. **Emergency Medical Treatment:** The principal or official representative of my child's school is authorized to secure medical care, automobile or ambulance transport to ***the closest*** Hospital or the nearest hospital facility when I/we cannot be immediately reached at the time of emergency. I/We will be responsible for the emergency medical charges upon receipt of statement

Your signature gives permission for all of the statements above which were not preceded by "No"

Parent Name (print): _____

Parent Signature: _____ Date: _____

Student Name (print): _____

Student Signature: _____ Date: _____

APPENDIX C

ORANGEVILLE CUSD #203

Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name_____ School Year_____
Last First Middle

Address_____ City/State_____

Phone No._____ Birthdate_____ Age_____ Class_____ Student ID No._____

Parent's Name_____ Phone No._____

Address_____ City/State_____

HISTORY FORM

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Have you or any family member or relative been diagnosed with cancer?		
52. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete_____ **Signature of parent/guardian**_____ **Date**_____

APPENDIX C (continued)

Pre-participation Examination

PHYSICAL EXAMINATION FORM Name_____
Last First Middle

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/Ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for 395 days from this date.

Yes No Limited Examination Date

Additional Comments:

Physician's Signature Physician's Name

Physician's Assistant Signature* PA's Name

Advanced Nurse Practitioner's Signature* ANP's Name

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.