



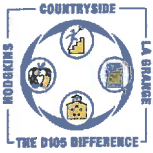
**Each student and his or her parent/guardian must read and sign this *Agreement to Participate* each year before being allowed to participate in interscholastic athletics or intramural athletics. The completed *Agreement* should be returned to the Coach.**

Student Name (*printed*) \_\_\_\_\_

1. I wish to participate in the interscholastic athletics or intramural athletics that are circled: basketball, cheerleading, cross country, marching band, soccer, softball, volleyball, wrestling, other (identify sports) \_\_\_\_\_. (Another *Agreement* must be signed if the student later decides to participate in a sport not circled above).
2. I acknowledge reading the eligibility rules of any group or association sponsoring any athletic activity in which I want to participate and I agree to abide by them.
3. I agree to abide by all conduct rules and will behave in a sportsmanlike manner. I agree to follow the coaches' instructions, playing techniques, and training schedule as well as all safety rules.
4. I understand that Board policy 7:305, *Student Athlete Concussions and Head Injuries*, requires, among other things, that a student athlete who exhibits signs, symptoms, or behaviors consistent with a concussion or head injury must be removed from practice or competition at that time and that the student will not be allowed to return to play or practice until he or she has successfully completed return-to-play and return-to-learn protocols, including having been cleared to return by the treating physician licensed to practice medicine in all its branches, physician assistant, treating advanced practice registered nurse, or a certified athletic trainer working under the supervision of a physician.
5. I am aware that with participation in sports comes the risk of injury, and I understand that the degree of danger and seriousness of risk vary significantly from one sport to another with contact sports carrying the highest risk. I am aware that participating in sports involves travel with the team. I acknowledge and accept the risks inherent in the sport(s) or athletics in which I will be participating and in all travel involved. I agree to hold the District, its employees, agents, coaches, School Board members, and volunteers harmless from any and all liability, actions, claims, or demands of any kind and nature whatsoever that may arise by or in connection with my participating in the school-sponsored interscholastic sport(s) or intramural athletics. The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees, and for all members of my family.

\_\_\_\_\_  
**Student Signature**

\_\_\_\_\_  
**Date**



**To be read and signed by the parent/guardian of the student:**

1. I am the parent/guardian of the above named student and give my permission for my child to participate in the interscholastic sport(s) or intramural athletics indicated. I have read the above *Agreement to Participate* and understand its terms.
2. I understand that all sports can involve many **risks of injury**, and I understand that the degree of danger and seriousness of risk vary significantly from one sport to another with contact sports carrying the higher risk. I am aware that participating in sports involves travel with the team. In consideration of the School District permitting my child to participate, I agree to hold the District, its employees, agents, coaches, Board members and volunteers harmless from any and all liability, actions, claims or demands of any kind and nature whatsoever that may arise by or in connection with the participation of my child in the sport(s) or athletics. I assume all responsibility and certify that my child is in good physical health and is capable of participation in the above indicated sport or athletics.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Day phone number: \_\_\_\_\_ Evening phone number: \_\_\_\_\_

Cell phone number: \_\_\_\_\_ Other: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Day phone number: \_\_\_\_\_ Evening phone number: \_\_\_\_\_

Cell phone number: \_\_\_\_\_ Other: \_\_\_\_\_

**GURRIE MIDDLE SCHOOL  
TEAM EXPECTATIONS AGREEMENT**

Welcome to the interscholastic team sports at Gurrie. We are a member of the Lyons Township Elementary School Athletic Conference, and the competition in each sport is governed by the rules of the conference, which have been developed and approved by representatives of each school at annual conference meetings.

Please read the information below with your parents, sign where indicated and return to your coach. The return of the signed form indicates that you understand its provisions and agree to the expectations for team sport participation at Gurrie.

1. I understand and agree that team practices are very important to the success of the team and my own development as an athlete. Attendance is expected at every practice. An absence or tardy must be followed by a written reason from a parent or teacher. Coaches often make decisions about playing time based on attendance at practice.
2. I understand and agree that in sports, playing time will often be based on level of skill and positive attitude.
3. I understand and agree that the rewards of interscholastic athletic competition include developing character, learning physical skills, and learning cooperative skills, as well as improving team performance. The rewards can be earned regardless of the role that is played on the team.
4. I understand and agree that as part of this team at athletic events I represent Gurrie Middle School, as well as myself, and exemplary conduct is expected at all times.
5. I understand and agree to the rules and guiding eligibility and conduct in the student/parent handbook.

A signature below indicates an agreement to abide by the expectations outlined above. Failure to abide by any part of the agreement may result in disciplinary consequences imposed by the coach, athletic director, dean or principal.

Student Name \_\_\_\_\_ Date \_\_\_\_\_

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

## STUDENTS

### **7:305 Student Athlete Concussions and Head Injuries**

The Superintendent or designee shall develop and implement a program to manage concussions and head injuries suffered by students. The program shall:

1. Fully implement the Youth Sports Concussion Safety Act, that provides, without limitation, each of the following:
  - a. The Board must appoint or approve member(s) of a Concussion Oversight Team for the District.
  - b. The Concussion Oversight Team shall establish each of the following based on peer-reviewed scientific evidence consistent with guidelines from the Centers for Disease Control and Prevention:
    - i. A return-to-play protocol governing a student's return to interscholastic athletics practice or competition following a force of impact believed to have caused a concussion. The Superintendent or designee shall supervise an athletic trainer or other person responsible for compliance with the return-to-play protocol.
    - ii. A return-to-learn protocol governing a student's return to the classroom following a force of impact believed to have caused a concussion. The Superintendent or designee shall supervise the person responsible for compliance with the return-to-learn protocol.
  - c. Each student and the student's parent/guardian shall be required to sign a concussion information receipt form each school year before participating in an interscholastic athletic activity.
  - d. A student shall be removed from an interscholastic athletic practice or competition immediately if any of the following individuals believes that the student sustained a concussion during the practice and/or competition: a coach, a physician, a game official, an athletic trainer, the student's parent/guardian, the student, or any other person deemed appropriate under the return-to-play protocol.
  - e. A student who was removed from interscholastic athletic practice or competition shall be allowed to return only after all statutory prerequisites are completed, including without limitation, the return-to-play and return-to-learn protocols developed by the Concussion Oversight Team. An athletic team coach or assistant coach may not authorize a student's return-to-play or return-to-learn.
  - f. The following individuals must complete concussion training as specified in the Youth Sports Concussion Safety Act: all coaches or assistant coaches (whether volunteer or a district employee) of interscholastic athletic activities; nurses, licensed healthcare professionals or non-licensed healthcare professionals who serve on the Concussion Oversight Team (whether or not they serve on a volunteer basis); athletic trainers; game officials of interscholastic athletic activities; and physicians who serve on the Concussion Oversight Team.
  - g. The Board shall approve school-specific emergency action plans for interscholastic athletic activities to address the serious injuries and acute medical conditions in which a student's condition may deteriorate rapidly.
2. Comply with the concussion protocols, policies, and by-laws of the Illinois High School Association (IHSA), including its *Protocol for Implementation of NFHS Sports Playing Rules*

for Concussion, which includes its *Return to Play (RTP) Policy*. These specifically require that:

- a. A student athlete who exhibits signs, symptoms, or behaviors consistent with a concussion in a practice or game shall be removed from participation or competition at that time.
  - b. A student athlete who has been removed from an interscholastic contest for a possible concussion or head injury may not return to that contest unless cleared to do so by a physician licensed to practice medicine in all its branches in Illinois or a certified athletic trainer.
  - c. If not cleared to return to that contest, a student athlete may not return to play or practice until the student athlete has provided his or her school with written clearance from a physician licensed to practice medicine in all its branches in Illinois, advanced practice registered nurse, physician assistant or a certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches in Illinois.
3. Require all student athletes to view the IHSA video about concussions.
  4. Inform student athletes and their parents/guardians about this policy in the *Agreement to Participate* or other written instrument that a student athlete and his or her parent/guardian must sign before the student is allowed to participate in a practice or interscholastic competition.
  5. Provide coaches and student athletes and their parents/guardians with educational materials from the IHSA regarding the nature and risk of concussions and head injuries, including the risks inherent in continuing to play after a concussion or head injury.
  6. Include a requirement for staff members to notify the parent/guardian of a student who exhibits symptoms consistent with that of a concussion.
  7. Include a requirement for staff members to distribute the Ill. Dept. of Public Health concussion brochure to any student or the parent/guardian of a student who may have sustained a concussion, regardless of whether or not the concussion occurred while the student was participating in an interscholastic athletic activity, if available.

LEGAL REF.:

105 ILCS 5/22-80.

105 ILCS 25/1.15.

CROSS REF.: 4:170 (Safety), 5:100 (Staff Development Program), 7:300 (Extracurricular Athletics)

Adopted: February 25, 2019

**LaGrange SD 105**

I have read and understand all of the above regarding student athlete concussions and head injury policies, protocols and by-laws.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# 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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> 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 \_\_\_\_\_

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# Pre-participation Examination



## PHYSICAL EXAMINATION FORM

EXAMINATION					
Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female		
BP / ( / )	Pulse	Vision R 20/		L 20/	Corrected <input type="checkbox"/> Y <input type="checkbox"/> 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 <sup>a</sup> • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)					
Pulses • Simultaneous femoral and radial pulses					
Lungs					
Abdomen					
Genitourinary (males only) <sup>b</sup>					
Skin • HSV, lesions suggestive of MRSA, tinea corporis					
Neurologic <sup>c</sup>					
MUSCULOSKELETAL					
Neck					
Back					
Shoulder/arm					
Elbow/forearm					
Wrist/hand/fingers					
Hip/thigh					
Knee					
Leg/Ankle					
Foot/toes					
Functional • Duck-walk, single leg hop					

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.  
<sup>c</sup>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 Assistant Signature\* \_\_\_\_\_

Advanced Nurse Practitioner's Signature\* \_\_\_\_\_

\*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.

### IHSA Steroid Testing Policy Consent to Random Testing (This section for high school students only) 2012-2013 school term

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/his/her 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](http://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/initiatives/sportsMedicine/files/IHSA\\_banned\\_substance\\_classes.pdf](http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_banned_substance_classes.pdf)

Signature of student-athlete \_\_\_\_\_ Date \_\_\_\_\_ Signature of parent-guardian \_\_\_\_\_ Date \_\_\_\_\_