



MORTON GROVE SCHOOL DISTRICT 70

6200 LAKE STREET • MORTON GROVE, IL 60053-2499 • (847) 965-6200 • Fax (847) 965-6234

CONSENT TO PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

I. To Be Completed By Student

I, _____, agree to abide by all of the rules set forth by Morton Grove School District 70 and the Coaching Staff while representing Morton Grove School District 70 and the community. My application to compete in interscholastic athletics for Park View School is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of Park View School. I have acknowledged having received the attached *Concussion Information Sheet* and a copy of the *District's* policy on *Student Athlete Concussions and Head Injuries*.

Student Signature: _____ Date: _____

II. To Be Completed by Parent or Guardian

1. I am the parent/guardian of the above named student and hereby give my consent for him/her to:
 - a. Represent his/her school in athletic activities as approved by examining physician; and
 - b. Accompany any school team of which he/she is a member on any of its local trips.
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. In consideration of the School District permitting my child to participate, I agree to hold the District or anyone acting on its behalf 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.
3. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may be reasonably necessary for the student in the course of such athletic activities or such travel.
4. I understand that the District's policy on *Student Athlete Concussions and Head Injuries*, requires, among other things, that a student athlete who exhibits signs and symptoms, or behaviors consistent with a concussion or head injury must be removed from participation or competition at that time and that such student will not be allowed to return to play unless cleared to do so by a physician licensed to practice medicine in all its branches or a certified athletic trainer.
5. I acknowledge having received the attached *Concussion Information Sheet*.
6. My son/daughter is adequately covered by personal or group insurance.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

This form must be signed and submitted along with the student's IHSA/IESA Pre-Participation Examination.



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

Signs observed by teammates, parents and coaches include:

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

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/>



Pre-participation 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 _____



Pre-participation Examination



PHYSICAL EXAMINATION FORM

Name _____
Last First Middle

EXAMINATION		Male	Female
Height	Weight	<input type="checkbox"/>	<input type="checkbox"/>
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 ^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	NORMAL	ABNORMAL FINDINGS	
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/Ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider 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.

IHSA Steroid Testing Policy Consent to Random Testing

(This section for high school students only)
2013-2014 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. 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

Signature of student-athlete _____ Date _____ Signature of parent-guardian _____ Date _____