Olympia High School and Middle School
ACTIVITIES Release Form

STUDENT INFORMATION

Student Name:_____
LAST FIRST MI

Student Address:_____

Home Phone:_____

Parents or Legal Guardians:_____

BIRTHDATE: _____ _____ _____
MONTH DAY YEAR

Contact if Parent Unavailable:_____

Phone:_____

CURRENT GRADE: _____

Family Doctor:_____ **Phone:**_____

In the event of an emergency requiring medical attention, I hereby grant permission to a physician or other hospital personnel designated by the Olympia Coaching Staff to attend to my son/daughter.

Signature of Parent/Guardian: _____

Activities Agreement

Olympia CUSD #16 believes it is the function of the activities program to provide activities which are interesting, wholesome, and enjoyable for all students. The overall objective of the program is to develop skills, sportsmanship, and a spirit of competitiveness for each participant. All parents/guardians and participants are asked to read and discuss the implications of participation in the high school and/or middle school activities program before signing this form.

Activities Code
(see Activities Code in Student Handbook or ask for a copy prior to signing)

As a student participant, I have received a copy of the Olympia Activities Code and have read and understand its contents. My son/daughter has my permission to practice and compete in the activities at Olympia High School and/or Olympia Middle School. I also approve of my son/daughter abiding by all the conditions of the Activity Code and the IHSA/IESA eligibility rules (found in the High School student handbook or on-line at www.ihsa.org & www.iesa.org). In addition, I realize such activity involves the potential for injury, which is inherent in all activities. I acknowledge that injuries may occur.

Date::_____ Signature of Student_____

Residency/Guardianship
I also verify that this student is living with his/her natural parents or legal guardians. I further understand that if my son/daughter is not living with both his/her parents, IHSA/IESA rules require the student to reside with his/her legal guardian to be able to compete athletically.

I agree to attach a copy of court filed legal documents as proof of legal guardianship, if necessary, due to divorce, legal separation, foster parent or adoptive parent status.

In the event residency/guardianship changes during the school year, the OHMS Activities Office **MUST** be notified immediately.

Date:_____ Signature of Parent/Guardian_____

PARENTAL PERMIT

Students are given the opportunity to participate in the following activities:

High School

Fall:	Boys' Cross Country, Girls' Cross Country, Girls' Swimming, Football, Volleyball, Boys' Golf, Girls' Golf, Boys' Soccer, Cheerleading, Marching Band, Flags, Fall Play, Tech. Crew, FFA
Winter:	Boys' Basketball, Girls' Basketball, Wrestling, Boys' Swimming, Cheerleading, Dance Team, Chorus, Speech, Jazz Band, Madrigals, Scholastic Bowl, Chess, Concert Band, Group Interpretation
Spring:	Boys' Track, Girls' Track, Softball, Baseball, Girls' Soccer, Show Choir, Spring Musical, Tech. Crew

Middle School

Fall:	Boys' Cross Country, Girls' Cross Country, Baseball, Softball, Girls' Basketball, Band
Winter:	Boys' Basketball, Wrestling, Volleyball, Cheerleading, Dance, Chorus, Literacy, Chess, Drama
Spring:	Boys' Track, Girls' Track, Scholastic Bowl

To participate in **High School activities**, students must be passing **ALL** courses each week and pass 3 of 4 courses per semester
To participate in **Middle School activities**, students must pass **ALL** courses each week

In addition to passing academic coursework, a parental and doctor's permission for athletics must be completed. Parents/Guardians must carry accident insurance or waiver for athletics. Parents/Guardians and student participants must also sign the Activities Agreement.

Doctor's Permit

Every student participating in Illinois High School Association (IHSA) or Illinois Elementary School Association (IESA) athletics must have a valid physical on file with the school. Physicals MUST be valid through an entire athletic season PRIOR to participation during that sport season (ex. Physical MUST be valid entire wrestling season to be able to START wrestling practice/season). Physicals are valid for 1 year (365 days) from the date of examination.

Insurance Release

Waiver

We, the undersigned parents/guardians of _____, a student at Olympia CUSD #16 Stanford, Illinois, who desires to participate in school sponsored activities for which accident insurance is required by the Board of Education, hereby certify that such student is covered by accident insurance with the following company and which policy we agree to keep in effect throughout the current school year:

Insurance Company:_____ Insurance Policy Number:_____

We, therefore, do not want said student included in any accident insurance plan provided by the school; and we hereby waive any claim against said school, and the officers and employees thereof for reimbursement for any expense incurred on account of any accidental injury to said student may suffer while participating in such activities.

Date:_____ Signature of Parent/Guardian:_____

School Insurance Receipt

Accident insurance has been purchased as specified by the school for the current year. The student may be issued equipment and be permitted to practice.

Insurance Plan

School Time Coverage:_____ 24 Hour Coverage:_____ Football Coverage:_____ School Verification:_____

Concussion Information Sheet

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 Return-to-Play Policy of the IESA and IHSA 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 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/

Student/Parent Consent and Acknowledgements
By signing this form, we acknowledge we have been provided information regarding concussions.

Student

Student Name (Print): _____ Grade: _____

Student Signature: _____ Date: _____

Parent or Legal Guardian

Name (Print): _____

Signature: _____ Date: _____

Relationship to Student: _____

Each year IESA 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.

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 7/1/2012 Reviewed 4/24/2013

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 in coordination
- 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

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 7/1/2012 Reviewed 4/24/2013

Student Name: DOB:__________
School: Date:__________

HOPEDALE REHABILITATION & Sports MEDICINE

Pre-Participation & Consent Form for Athletic Training Outreach Services

Release of Medical Information

I/we expressly permit the contracted athletic training staff and medical consultants to release information regarding the student-athlete's medical history, record of injury, surgery, participation status and rehabilitation results in accordance with the Notice of Privacy Practices and applicable state and federal laws, or school policy, including but not limited to The Family Educational Rights and Privacy Act (20 U.S.C. 1232g; 24 CFR Part 99) and the Health Insurance Portability and Accountability Act (P.L. 104-191).

I/we expressly permit the contracted athletic training staff and medical consultants acting on behalf of the Hopedale Medical Complex to obtain information from other health care providers regarding the student athlete's medical history, record of injury, surgery, participation status and rehabilitation results with the above listed policies and laws. I/we grant permission for any health care provider to release to the contracted athletic training staff and any and all medical records related to the evaluation, treatment, and rehabilitation of any injury/illness sustained by the student-athlete.

This authorization shall expire one calendar year from the date of the signature. It is subject to revocation by the student-athlete or his/her parent/ guardian (if the student-athlete is under the age of 18), if notice is provided in writing, except to the extent that the action has been taken in reliance thereon. Please be aware that once we disclose this information per your instructions, the information is subject to re-disclosure and may be no longer protected by the FERPA or HIPAA.

Acknowledgement of Risk

Participation in athletics is potentially hazardous/dangerous activity. Serious injuries, including permanent paralysis and even death can occur. Neither the **Hopedale Medical Complex** nor any of its employees assume any responsibility in the event of an accident. In consideration of the below signed student-athlete being permitted to participate in the above listed sports, I/we hereby release above named institutions and its employees, together with all persons assisting with any phase of such activities, from all liability and responsibility in connection with such activity. I/we further agree to indemnify and hold harmless said parties from all claims hereafter made and asserted by or on behalf of the below signed student-athlete, his/her parents, guardian's), heirs, executors, or assigns.

Consent to Treat

I/we expressly permit the contracted athletic training staff and medical staff acting on behalf of the Hopedale Medical Complex (HMC) to evaluate and treat any injury/illness that occurs as a result of the athletes participation in athletics. This includes any and all reasonable and necessary care including therapeutic modalities, rehabilitation, preventative instruction, and use of EMS services as needed. In the event your athlete gets injured off school grounds, I authorize an HMC representative to facilitate evaluation, treatment/care and/or EMS transportation or other forms of transportation for the appropriate care of the injured athlete. I understand that an HMC Certified Athletic Trainer will contact the athlete's parent or guardian as soon as possible in the event of an emergency situation.

- -

****** PLEASE CUT THIS SECTION OFF AND KEEP FOR YOUR RECORDS INCASE YOU NEED TO CONTACT YOUR ATC! ******

DEEMACK / HARTEM	DELAVAN / TREMONT	OLYMPIA
Athletic Trainer: Emily Whitson, MS, ATC	Athletic Trainer: Greg Eberle, ATC, CES, CEAS	Athletic Trainer: Josh Blaum, MS, ATC
Office: 309.449.4501 Cell: 309.533.1891 Fax: 309.449.4525	Office: 309.449.4501 Cell: 309.202.2955 Fax: 309.449.4525	Office: 309.449.4501 Cell: 217.412.3974 Fax: 309.449.4525
Email: ewhitson@hopedalemc.com	Email: geberle@hopedalemc.com	Email: jblaum@hopedalemc.com

Student Name: DOB:_____
School: Date:_____

Contact Information

Athletes Name (Printed Clearly):

Date of Birth: Age:

Year in School: Seventh Grade Eighth Grade Freshman Sophomore Junior Senior

Sport(s):

Email Address: Mailing Address:

Phone Number: __Cell __Home:

Parent or Guardian to Contact in case of an Emergency:
Name:

Phone Number:

Other Form of Contact:

Best time of day to contact you:

Best method of communication: phone call text message email other_____

Agreement

My signature below indicates that I have read the information in this document. Therefore, I understand it completely and in the event I have any questions, I may contact the school's Certified Athletic Trainer and/or refer to the Hopedale Medical Complex website as documented for further information.

Athletes Signature: _____
(if 18 years):

Parent or Guardian Signature: _____
(if athlete is 17 years or younger)

Parent or Guardian Printed Signature: _____

Date:

HMC
Hopedale Medical Complex

Olympia Student-Athlete Health History Form

This form is to be filled out prior to the school year to help the contracted athletic trainer (ATC) with any health history about your student athlete. This is very important so the ATC knows how to better assist your student-athlete.

Athlete Name: _____

1. **Pre-Disposed Conditions** (Ex- Pathologies student athlete was born with)

2. **History of Concussion** (Has your athlete had any concussions? If so, when)

3. **Cardiopulmonary / Respiratory** (Any heart or lung problems. Ex- Sickle Cell / Asthma)

4. **Neurological** (Ex- Seizure, History of Stingers)

5. **Allergies** (Ex-Bees , Latex, Peanuts)

6. **Orthopedic Injuries** (Ex- Surgeries, Previous injuries requiring doctor/ATC visits)

Parent Signature:_____ Date: _____

Parent Printed Name:_____

HOPEDALE REHABILITATION & Sports MEDICINE

Action Plan for Concussion Management

Education

1. The certified athletic trainer will educate parents, athletes, and coaches on the recognition of signs and symptoms of a concussion and follow up care for the athlete by distribution and public posting of the IHSA Protocol for NFHS Concussion Playing Rule.

2. Following distribution of the IHSA Protocol for NFHS Concussion Playing Rule, consent to treat document *must be signed* by the parent/guardian prior to the sports season in order for the contracted athletic trainer to assess the athlete and provide care.

3. Communication between the contracted athletic trainer and parent/guardian in regards to the concussed athlete will be initiated by the athletic trainer in order to maintain a safe transition back to activity.

Preseason

Neurocognitive (brain function) Baseline Testing of the Student-Athlete
ImPact Computer-Based Test

1. Athletes will take an ImPACT baseline test prior to participation in their sport activities for the school year.

2. The baseline test is administered at the freshman and junior levels.

3. If an athlete at any class level is participating for the first time in any sport, he/she needs to have a baseline test.

4. The baseline test is administered at the high school by the contracted athletic trainer.

5. If an athlete plays multiple sports in the course of a school year, they only take the baseline test once.

6. The **ImPact baseline test** is a free test.

7. For further information on the ImPACT concussion test, see **www.impacttest.com.**

Reducing the Risks of a Concussion

The contracted athletic trainer will work with the coaching staff of each sport to:

1. Recommend strength and conditioning techniques to increase neck and overall strength
2. Educate on proper helmet/facemask fitting (football, softball, baseball)
3. Mouth guard usage
4. Nutritional considerations
5. Overall sports safety for each sport

Diagnosis and Care of a Concussed Athlete

1. If an athlete shows signs or symptoms of a concussion per IHSA Protocol for NFHS Concussion Playing Rule, that athlete is to be removed immediately from their activity and not to return until evaluated by a licensed healthcare professional.

   IHSA mandated licensed healthcare professional per Illinois State Law HB200: Medical Doctor (MD) or Certified Athletic Trainer working under the direction of an MD

2. A comprehensive plan of care by the licensed healthcare professional needs to be explained and implemented for the concussed athlete and parents/guardian.

3. The athlete must have a signed document by the medical doctor or certified athletic trainer stating a release of medical care and a plan for return-to-sport activity. This must be presented to the school before an athlete can return to activities pertaining to their sport.

Return-to-Learn Plan

Students with a concussion may need adjustments academically to help minimize symptoms and increase recovery time. These adjustments will be individualized to the student-athlete and the symptoms that they are experiencing from the concussion. A team approach will be utilized that includes the licensed healthcare professional managing the concussion, the school team (teachers and principal), and the family. The return to learn and return to sport monitoring and assessment will occur concurrently. Students should be performing at their academic baseline with complete resolve of signs and symptoms of the concussion before they can initiate a return to sport activity plan.

Education of all individuals involved with the student who sustains a concussion is paramount for providing the appropriate accommodations, rest, and classroom adjustments. Teachers will receive the CDC return to learn fact sheet, to allow them to familiarize themselves on what to look for in the concussed student that is returning to the classroom.

Return-to-Sport Activity Plan

If an athlete has complete resolve of signs and *symptoms at rest* and released by their licensed healthcare professional for return-to-sport activities, these two return-to-sport activities are in place at the school to provide a safe return:

1. **The athlete takes an ImPact follow-up test to determine "normal" brain function as compared to the athlete's baseline test after sustaining a concussion. (recommended)**

The follow-up test is recommended and not required. The tests will be taken at Olympia High School and the results will be sent to the Illinois Neurological Institute (INI). These follow up tests will be at no cost to the patient. The athlete does not need to go into to office and the athlete will only be charged if the concussion requires an office visit.

All the results of the test are sent by INI to the contracted athletic trainer from the Hopedale Medical Complex. The test results can be sent to the athlete's treating physician by the contracted athletic trainer upon request of the parent.

2. **Physical stress test to determine if signs or symptoms return after increasing blood pressure and heart rate. (required)**

The physical stress test after a concussion was developed by the National Athletic Trainers Association, American Academy of Neurology and multiple national organizations to ensure a safe return-to-sport. This test will occur over 2-5 days depending on how the athlete physically responds. The primary purpose of this testing is to stress the athlete's body through a series of cardiovascular testing, jumping and agilities. It is the intention of the test to try and reproduce signs or symptoms. If no signs or symptoms are detected after such testing, it is safe for that athlete to return to their sport. It is required that they participate in practices without restrictions prior to competing in a game.

- ✓ All testing will be administered by the school's Certified Athletic Trainer.
- ✓ All testing will be performed at the school.
- ✓ The Certified Athletic Trainer will sign off on a release to practice if the athlete passes the physical stress test.

Final Comments

Once an athlete has been cleared by a licensed healthcare professional and passes (at the minimum) the physical stress test with NO signs or symptoms, the athlete is safe to begin return-to-sport activities during practice sessions and progressing towards game competition.

It is our goal as the contracted athletic trainers for your school to provide optimal care for your athlete and ensure a safe return to sport at the safest time. If you have any questions, please do hesitate to contact the contracted athletic trainer.

Contracted Medical Institution:

Hopedale Medical Complex
309-449-4501
Medical Director: Dr. Lawrence Rossi, MD
HMC Senior Director and the Rehabilitation and Sports Medicine Director: Emily Whitson, MS, ATC
Assistant Director of Sports Medicine: Greg Eberle, ATC, CES

Sources of information as stated in this document:

www.lhsa.org (click on the sports medicine icon for information)

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_____

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.

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 _____