**WHITESIDE SCHOOL DISTRICT 115**
**111 Warrior Way, Belleville, Illinois 62221**
**Telephone 618 239-0000**
**Middle School Fax 618 239-9240**
**Elementary School Fax 618 233-7931**

**http://www.wssd115.org**

## Student Information

**Student's Name:**_____

**Grade:**_____

**Please circle the sports you are interested in trying out for this year:**

| | | |
|---|---|---|
| Baseball/ Softball | Soccer | Cross Country |
| Basketball | Cheerleading | Volleyball |
| Bowling | Track and Field | Golf |

Office Use Only:

| | |
|---|---|
| Physical On File | |
| All Sports Forms Signed | |
| Added to Sports List | |

*Whiteside's mission is to help all learners reach their maximum potential so that they may become tomorrow's leaders.*

*WHITESIDE SCHOOL DISTRICT 115*
*111 Warrior Way*
*Belleville, Illinois 62221*

**Telephone 618 239-0000**
**Middle School Fax 618 239-9240**
**Elementary School Fax 618 233-7931**

## Certificate of Physical Fitness for Participation in Athletics –2022-2023

*To be submitted to the Superintendent*

| | |
|---|---|
| Student: | Grade: |
| Sport or Activity: | |

I am the parent(s)/guardian(s) of the above student. I certify that my child/ward is in good physical health and is capable of participation in the above mentioned sport or activity. No need exists to limit his/her participation. I assume full responsibility for his/her physical condition and participation. I will notify you of any changes in his/her physical condition. I have completed and submitted the ***Authorization for Medical Treatment*** form allowing the school to seek medical treatment for my child in the event of a medical emergency when reasonable attempts to contact me are unsuccessful. If my child requires or may need medication while participating in athletics, I have completed and submitted the ***School Medication Authorization Form.***

| | | | |
|---|---|---|---|
| Parent(s)/Guardian(s) Name: | | | |
| Home Address: | | | |
| Telephone Number: | | Business Phone: | |
| Child/Ward's Date of Birth: | | | |
| Physician's Name: | | Telephone Number: | |

Medical History:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Heart Condition | ☐ | ☐ | Epilepsy | ☐ | ☐ |
| Allergies | ☐ | ☐ | Asthma | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Other | | |

1. Injuries and/or operations during the past year? (include dates)

2. Has your child/ward's physical activity been restricted during the past year? (Reason and Duration)

3. Is your child/ward taking any medication? ☐ Yes ☐ No

If yes, why? Name of medication:

| | |
|---|---|
| Signature of Parent(s)/Guardian(s); | |
| Date: | |

*Whiteside's mission is to help all learners reach their maximum potential so that they may become tomorrow's leaders.*

**WHITESIDE SCHOOL DISTRICT 115**
**111 Warrior Way, Belleville, Illinois 62221**
**Telephone 618 239-0000**
**Middle School Fax 618 239-9240**
**Elementary School Fax 618 233-7931**
**http://www.wssd115.org**

## Agreement to Participate

*To be completed by the student-participant and submitted to the Superintendent*

Student: _____

Sport or Activity: _____

In consideration of the Whiteside School District 115 permitting me to participate in the above sport or activity, I agree as follows:

1. I will abide by all conduct rules and will behave in a sportsmanlike manner.
2. I will follow the coach/sponsor's instructions, playing techniques, training schedule and safety rules for the above sport or activity.
3. I acknowledge that I am aware that participation in the above sport or activity may involve **many risks of injury**. A serious injury may result in physical impairment or even death. I hereby assume all the risks associated with participation and agree to hold Whiteside School District 115, its employees, agents, coaches, School Board members, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of any kind and nature whatsoever which may arise by or in connection with my participation in the above activity or sport. 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 Completed By The Parent/Guardian:*

I, _____ am the parent(s)/guardian(s) of the above named student. I have read the above Agreement to Participate and understand its terms. I understand that all sports can involve many **RISKS OF INJURY**. In consideration of the School District permitting my child/ward to participate in the above sport or activity, I agree to hold Whiteside School District 115, its employees, agents, coaches, School Board members and volunteers harmless from any and all liability, actions, causes of action, debts, claims or demands of any kind and nature whatsoever which may arise by or in connection with the participation of my child/ward in the above sport or activity. I understand and accept the selection process and the expectations as set forth by the coach of this activity. I will provide transportation to and from practices and scheduled events when needed. I assume all responsibility and certify that my child is in good physical health and is capable of participation in the above mentioned sport/activity.

Signature of Parent(s)/Guardian(s): _____

Date: _____

*Whiteside's mission is to help all learners reach their maximum potential so that they may become tomorrow's leaders.*

**WHITESIDE SCHOOL DISTRICT 115**
**111 Warrior Way Belleville, Illinois 62221**
**Telephone 618 239-0000**
**Middle School Fax 618 239-9240**
**Elementary School Fax 618 233-7931**
**http://www.wssd115.org**

## Medical Authorization Form

*To be submitted to the Superintendent*

| | | | |
|---|---|---|---|
| Student: | | Grade: | |
| Sport/Activity: | | | |
| Home Address: | | | |
| Home Phone: | | Birth Date: | |

**To whom it may concern**: In the event reasonable attempts to contact me at the locations listed below have been unsuccessful, I, as parent or legal guardian of the above student, do hereby authorize (1) the treatment by a qualified and licensed medical doctor of my child/ward in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed; and (2) the transfer of my child/ward to any hospital reasonably accessible.

This release form is completed and signed of my own free will with the purpose of authorizing medical treatment under emergency circumstances in my absence.

| | | | |
|---|---|---|---|
| Name and relation to student (please print): | | | |
| Address: | | | |
| | | | |
| Home Phone: | | Business Phone: | |
| Emergency contact: | | | |
| Home Phone: | | Business Phone: | |
| Physician's name: | | Physician's Phone: | |

*Please list specific medical allergies, medicines, or other conditions on other side of this form.*

| | |
|---|---|
| Signed : | |
| Date: | |

Whiteside School District #115 maintains Students Accident Insurance coverage on all students while in attendance at school, school-sponsored events and activities, including school athletics. Submission of claims is the responsibility of the parent. This insurance carries a deductible of the greater of $0 or the amount paid or payable for the same injury by any other plan on which the student is covered.

## 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. The district will follow the graduated return to school protocol developed by the Sports Concussion Institute.

**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 the 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/

| | | |
|---|---|---|
| Student-athlete Name Printed | Students-athlete Signature | Date |
| Parent or Legal Guardian Printed | Parent or Legal Guardian Signature | Date |

Adapted from the CDC and the 3rd International Conference on Concussion in Sport Document Created 7/1/2011

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

| **Signs observed by teammates, parents and coaches include:** |
|---|
| • Appears dazed<br>• Vacant facial expression<br>• Confused about assignment<br>• Forgets plays<br>• Is unsure of game, score, or opponent<br>• Moves clumsily or displays incoordination<br>• Answers questions slowly<br>• Slurred speech<br>• Shows behavior or personality changes<br>• Can't recall events prior to hit<br>• Can't recall events after hit<br>• Seizures or convulsions<br>• Any change in typical behavior or personality<br>• Loses consciousness |

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 7/1/2011

# WHITESIDE SCHOOL DISTRICT 115

## Waiver and Release of Liability Relating to Coronavirus/COVID-19 for District Athletics and Voluntary Strength Training and Conditioning Sessions

SARS-CoV-2, the virus causing the COVID-19 illness, is extremely contagious and is believed to spread mainly from person-to-person contact and through respiratory droplets. COVID-19 may also be spread from asymptomatic or pre-symptomatic individuals. Spread is more likely when people are in close contact with one another (within about 6 feet). Evidence has shown that COVID-19 can cause serious and potentially life threatening illness and even death, including, but not limited to, complications such as respiratory failure, acute respiratory distress syndrome, cardiac injury, liver injury, infections, among other known and unknown illness and injury.

Playing sports and/or participating in voluntary strength training and conditioning sessions with other individuals, in any capacity during this time of pandemic, holds an inherent risk of a student-athlete becoming infected and potentially then infecting other individuals, such as their household members. Whiteside School District 115 ("the District") cannot prevent your student-athlete from becoming exposed to, contracting, or spreading COVID-19 while participating in athletics and voluntary strength training and conditioning sessions in the District. Therefore, if you choose to allow your student-athlete to participate in District athletics and voluntary strength training and conditioning sessions, your student-athlete may be exposed to and/or may contract COVID-19. Please consult your student-athlete's primary care physician about this risk and any increased risk that may be caused by any pre-existing health conditions your student-athlete may have, prior to returning to athletics and participating in voluntary strength training and conditioning sessions.

**ASSUMPTION OF RISK: I have read and understood the above warning concerning COVID-19.** I hereby knowingly and voluntarily accept and assume the risk that I may be exposed to, infected by, and/or contract COVID-19 for myself and/or my student-athlete by participating in District athletics and voluntary strength training and conditioning sessions and that such exposure or infection may result in quarantine, personal injury, illness, permanent disability, and/or death. My student-athlete's ability to participate in District athletics and voluntary strength training and conditioning sessions is of such value to my student-athlete and me that I accept and assume all risks, hazards and losses related to being exposed to, contracting, and/or spreading COVID-19.

I understand and acknowledge that the District cannot guarantee any student-athlete's safety from COVID-19 while participating in District athletics and voluntary strength training and conditioning sessions. I understand that the District has made no representations regarding the safety of participating in District athletics and voluntary strength training and conditioning sessions and that I have had the opportunity to discuss the District athletic program's conditions prior to participation.

I agree that my student-athlete and I are personally responsible for our safety and actions while participating in athletics and voluntary strength training and conditioning sessions in the District. My student-athlete and I agree to comply with all District policies and rules, including, but not limited to, all District policies, guidelines, signage, and instructions.

**WAIVER OF LAWSUIT/LIABILITY: In consideration for my student-athlete's participation in District athletics and voluntary strength training and conditioning sessions, I hereby, for myself, my student-athlete, and on behalf of my and my student-athlete's heirs, executors, administrators, successors, agents, assigns, and representatives, knowingly and voluntarily forever release, covenant not to sue, and fully waive our right to bring suit against Whiteside School District No. 115 and its board members, officers, agents, representatives, employees, insurers and all other persons in their individual and official capacities (referred to collectively as the "Released Parties") in connection with exposure, infection, and/or spread of COVID-19 related to my student-athlete's participation in District athletics and voluntary strength training and conditioning sessions.** I understand that this waiver means I give up my right to bring any claims or lawsuits for injury including, but not limited to, personal injury, death, disease or property losses, damages and/or any other losses, including, but not limited to, claims of negligence and give up any claim I may have to seek damages, whether known or unknown, foreseen or unforeseen.

**INDEMNIFICATION: In consideration for my student-athlete's participation in District athletics and voluntary strength training and conditioning sessions, I hereby knowingly and voluntarily agree to indemnify, hold harmless, and defend the Released Parties from and against any and all liability or present or future claims or lawsuits for injury, including, but not limited to, personal injury, death, disease or property losses, damages, and/or any other losses, whether known or unknown, WHETHER ARISING FROM THE NEGLIGENCE OF THE RELEASED PARTIES OR OTHERS, including claims for attorney's fees, arising out of or in any way connected with exposure, infection, and/or spread of COVID-19 related to my student-athlete's participation in District athletics and voluntary strength training and conditioning sessions.**

**CHOICE OF LAW**: I understand and agree that the law of the State of Illinois will apply to this contract. The terms of this agreement do not limit the immunities available to the District under Illinois and federal law. I understand that this Waiver and Release is intended to be as broad and inclusive as permitted by the laws of the State of Illinois, and I agree that if any portion is held invalid, the remainder of the Waiver and Release will continue in legal force and effect.

**I AKNOWLEDGE THAT I HAVE CAREFULLY READ AND FULLY UNDERSTAND ALL PROVISIONS OF THIS WAIVER AND RELEASE AND HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS RELATED TO IT. I FULLY UNDERSTAND THAT BY SIGNING THIS FORM I AM GIVING UP LEGAL RIGHTS AND/OR REMEDIES THAT MAY OTHERWISE BE AVAILABLE AND I FREELY AND KNOWINGLY ASSUME THE RISK AND VOLUNARILY WAIVE MY RIGHTS CONCERNING LIABILITY AS DESCRIBED ABOVE.**

| | |
|---|---|
| Student-Athlete Name (printed) | Parent Name (printed) |
| Student-Athlete Signature Date | 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: ☐ 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<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart [a]<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI) | | |
| Pulses<br>• Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only)[b] | | |
| Skin<br>• 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<br>• 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.

| Last | First | Middle | Birth Date Month/Day/ Year | Sex | School | Grade Level/ ID |
|---|---|---|---|---|---|---|
| | | | | | | |

**HEALTH HISTORY** TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

| ALLERGIES (Food, drug, insect, other) | Yes / No | List: |
|---|---|---|
| | | |

| MEDICATION (Prescribed or taken on a regular basis.) | Yes / No | List: |
|---|---|---|
| | | |

| | | | |
|---|---|---|---|
| Diagnosis of asthma? Child wakes during night coughing? | Yes Yes | No No | |
| Birth defects? | Yes | No | |
| Developmental delay? | Yes | No | |
| Blood disorders? Hemophilia, Sickle Cell, Other? Explain. | Yes | No | |
| Diabetes? | Yes | No | |
| Head injury/Concussion/Passed out? | Yes | No | |
| Seizures? What are they like? | Yes | No | |
| Heart problem/Shortness of breath? | Yes | No | |
| Heart murmur/High blood pressure? | Yes | No | |
| Dizziness or chest pain with exercise? | Yes | No | |
| Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading) | | | |
| Ear/Hearing problems? | Yes | No | |
| Bone/Joint problem/injury/scoliosis? | Yes | No | |

| | | | |
|---|---|---|---|
| Loss of function of one of paired organs? (eye/ear/kidney/testicle) | Yes | No | |
| Hospitalizations? When? What for? | Yes | No | |
| Surgery? (List all.) When? What for? | Yes | No | |
| Serious injury or illness? | Yes | No | |
| TB skin test positive (past/present)? | Yes* | No | *If yes, refer to local health department. |
| TB disease (past or present)? | Yes* | No | |
| Tobacco use (type, frequency)? | Yes | No | |
| Alcohol/Drug use? | Yes | No | |
| Family history of sudden death before age 50? (Cause?) | Yes | No | |
| Dental ☐ Braces ☐ Bridge ☐ Plate Other | | | |

Information may be shared with appropriate personnel for health and educational purposes.
**Parent/Guardian Signature** **Date**

**PHYSICAL EXAMINATION REQUIREMENTS** **Entire section below to be completed by MD/DO/APN/PA**
**HEAD CIRCUMFERENCE if < 2-3 years old** **HEIGHT** **WEIGHT** **BMI** **B/P**

**DIABETES SCREENING** (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
**Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

**LEAD RISK QUESTIONNAIRE:** Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

**Questionnaire Administered?** Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

**TB SKIN OR BLOOD TEST** Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

**No test needed** ☐ **Test performed** ☐ **Skin Test: Date Read** / / **Result: Positive** ☐ **Negative** ☐ **mm**_____
**Blood Test: Date Reported** / / **Result: Positive** ☐ **Negative** ☐ **Value**

| LAB TESTS (Recommended) | Date | Results | | Date | Results |
|---|---|---|---|---|---|
| Hemoglobin or Hematocrit | | | Sickle Cell (when indicated) | | |
| Urinalysis | | | Developmental Screening Tool | | |

| SYSTEM REVIEW | Normal | Comments/Follow-up/Needs | | Normal | Comments/Follow-up/Needs |
|---|---|---|---|---|---|
| Skin | | | Endocrine | | |
| Ears | | Screening Result: | Gastrointestinal | | |
| Eyes | | Screening Result: | Genito-Urinary | | LMP |
| Nose | | | Neurological | | |
| Throat | | | Musculoskeletal | | |
| Mouth/Dental | | | Spinal Exam | | |
| Cardiovascular/HTN | | | Nutritional status | | |
| Respiratory | | ☐ Diagnosis of Asthma | Mental Health | | |
| Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid) | | | Other | | |

**NEEDS/MODIFICATIONS** required in the school setting

**DIETARY** Needs/Restrictions

**SPECIAL INSTRUCTIONS/DEVICES** e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

**MENTAL HEALTH/OTHER** Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

**EMERGENCY ACTION** needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
**PHYSICAL EDUCATION** Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** Yes ☐ No ☐ Modified ☐

**Print Name** (MD,DO, APN, PA) **Signature** **Date**

**Address** **Phone**

# State of Illinois
# Certificate of Child Health Examination

| Student's Name<br>Last First Middle | Birth Date<br>Month/Day/Year | Sex | Race/Ethnicity | School /Grade Level/ID# |
|---|---|---|---|---|
| Address Street City Zip Code | Parent/Guardian | Telephone # Home | | Work |

**IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.**

| REQUIRED Vaccine / Dose | DOSE 1 MO DA YR | DOSE 2 MO DA YR | DOSE 3 MO DA YR | DOSE 4 MO DA YR | DOSE 5 MO DA YR | DOSE 6 MO DA YR |
|---|---|---|---|---|---|---|
| DTP or DTaP | | | | | | |
| Tdap; Td or Pediatric DT (Check specific type) | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT |
| Polio (Check specific type) | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV |
| Hib Haemophilus influenza type b | | | | | | |
| Pneumococcal Conjugate | | | | | | |
| Hepatitis B | | | | | | |
| MMR Measles Mumps. Rubella | | | | | | |
| Varicella (Chickenpox) | | | | | | |
| Meningococcal conjugate (MCV4) | | | | | | |
| **RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose** | | | | | | |
| Hepatitis A | | | | | | |
| HPV | | | | | | |
| Influenza | | | | | | |
| Other: Specify Immunization Administered/Dates | | | | | | |

**Comments:**

**Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.** If adding dates to the above immunization history section, put your initials by date(s) and sign here.

**Signature** **Title** **Date**

**Signature** **Title** **Date**

**ALTERNATIVE PROOF OF IMMUNITY**

**1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.**

***MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR**

**2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.** Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

**Date of Disease** **Signature** **Title**

**3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps** ☐Rubella ☐Varicella Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

**Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature:** _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

**Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.**