WHITESIDE MIDDLE SCHOOL
ATHLETIC TEAM TRY-OUT & PARTICIPATION REQUIREMENTS
2018-2019 School Year

All students wanting to participate in any sports activity listed below MUST have the following turned in to the middle school office by the deadline in order to participate in try-outs. Questions may be directed to Mr. Jacob at 239-0000 x 3605

- Current physical (less than one year old as of tryout date)
- 2018-2019 Sports packet (only one required per school year)
  - Certificate of Physical Fitness for Participation
  - Agreement to Participate
  - Medical Authorization Form
  - Concussion Information Acknowledgement
- Registration fee and all incidental fees (lunch, IDs, library, etc.) paid
- Minimum 2.0 GPA (not applicable for August tryouts)

Students will not be permitted to tryout if any of the above conditions are not met by the deadlines indicated below.

Early Fall Sports
Baseball, Softball, Soccer
Tryouts first week of August
Physical, sports packet, and fees due by **Wednesday, July 25**

Cross Country
Tryouts Monday, August 20, 2018 from 3:00-4:00 pm
Physical, sports packet, and fees due by **Thursday, August 16**

Cheerleading
Tryouts third week of September
Physical, sports packet, and fees due by **Wednesday, September 5**

Late Fall Sports
Boys' Basketball (Grades 5-8), Girls Basketball (Grades 5-8)
Tryouts first week in October
Physical, sports packet, and fees due by **Wednesday, September 26**

Winter Sports
Boys' Volleyball (Grades 7-8), Girls' Volleyball (Grades 5-8), Bowling
Tryouts first week in January
Physical, sports packet, and fees due by **Wednesday, December 12**
Minimum 2.0 GPA at end of 1st semester

Spring Sports
Boys' & Girls' Track (Grades 6-8)
Tryouts third week in March
Physical, sports packet, and fees due by **Wednesday, March 13**
Minimum 2.0 cumulative GPA

Note: An **Activity Fee** of $25 for the first activity and $10 for each additional activity is due two (2) weeks following tryouts or by the first game, whichever comes first.

Students with any outstanding fees on any given Monday will have until Friday of that week to make payment. Students will be required to "sit out" the following week until all fees are paid. If not paid by Friday of the second week, the student will be removed from the team.

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

Certificate of Physical Fitness for Participation in Athletics – 2018-2019

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
111Warrior Way
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AGREEMENT TO PARTICIPATE

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. The completed *Agreement* should be returned to the middle school office.

Student name (printed)_____

1. I wish to participate in the interscholastic athletics during the 2018-2019 school year.

2. I acknowledge reading the eligibility rules as outlined in the student handbook under "Eligibility Standards for Extra-Curricular Activities", coach's rules, and district rules for student conduct, and I agree to abide by them.

3. Before I am allowed to participate, I must: (a) provide the School District with a current certificate of physical fitness and completed sports packet, (b) have a minimum 2.0 GPA, and (c) have no outstanding fees.

4. 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.

5. 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 or a certified athletic trainer under the supervision of a physician.

6. 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). 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 or ward to participate in the interscholastic athletics. 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**_____

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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	• 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 plays)
• Drowsiness	
• Change in sleep patterns	• Repeating the same question/comment

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

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

Graduated Return to School Protocol

NAME:_____

Recovery Stage 1

Complete Physical and Cognitive Rest until Medical Clearance

- No School Attendance
- Strict Technology Limits
- REST

Symptom free for 24 hours

YES:
Begin Stage 2
NO:
Continue Resting

Date Attained:

Recovery Stage 2

Return to School with Academic Accommodations

- Continue limits on technology use
- Avoid heavy backpacks
- No Tests, PE, Band or Chorus
- Monitor Symptoms
- REST at home

Symptom free for 24 hours

YES:
Begin Stage 3
NO:
Rest until Symptom Free

Date Attained:

Recovery Stage 3

Continue Academic Accommodations

- Attend School full time if possible
- Increase work load gradually (testing, homework, etc.)
- Monitor Symptoms
- Incorporate light aerobic activity
- REST at home

Symptom free for 24 hours

YES:
Begin Stage 4
NO:
Return to Stage 2 until Symptom Free

Date Attained:

Recovery Stage 4

Full Recovery to Academics

-Attend school full time
- Self-Advocate at school (meet due dates, etc.)
- Resume normal activities
- Return to sports following graduated return to play

Symptom free for 24 hours

YES:
Return to School
NO:
Return to Stage 3 until Symptom Free

Date Attained:

NOTES:

Reference: HeadSmart Handbook: A Healthy Transition After Concussion (2010) www.Southshorehospital.org

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date 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.

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?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during night coughing?	Yes	No					
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes	No					

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old HEIGHT WEIGHT BMI BP

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**